

# New Players for a New Era

## Leading Health Promotion into the 21st Century

4th International Conference on Health Promotion  
Jakarta, Indonesia 21-25 July 1997

### SPEECHES AND PRESENTATIONS

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## **SPEECHES AND PRESENTATIONS**

**Fourth International Conference on Health Promotion  
Jakarta, 21-25 July 1997**



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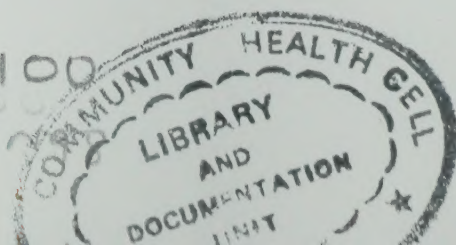
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**Speeches and Presentations**  
at the  
**Fourth International Conference on Health Promotion**

**New Players for the New Era**  
**Leading health promotion into the 21<sup>st</sup> century**  
Jakarta, Indonesia, 21-25 July 1997

**Foreword**

The Health Education and Health Promotion Unit (HEP) presents you this selection of Speeches and Presentations addressed at the Fourth International Conference on Health Promotion, held in Jakarta, Indonesia, on July 1997, on the theme "New Players for a New Era - leading health promotion into the twenty-first century".

The Conference, which acted as a catalyst for health promotion action, was held against the background of the major global changes that have taken place since the Ottawa Conference in 1986. It had three objectives: 1) to review and evaluate the impact of health promotion; 2) to identify innovative strategies to achieve success in health promotion; 3) to facilitate the development of "partnership" in health promotion to meet the global health challenges.

The conference confirmed that health promotion is a practical approach to achieve greater equity in health and that the five strategies set out in the Ottawa Charter are essential for success.

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These various presentations underline the effectiveness of health promotion, showing clear evidence that comprehensive approaches to health promotion are the most effective. Grouped under the main themes of the conference, these speeches and presentations illustrate the global challenge for health promotion; responses in health promotion and leading changes in health promotion.

The Jakarta Declaration, which was unanimously endorsed by its participants, reflects the firm commitment of the conference participants to build partnerships, and describes the wide range of resources needed to tackle global health problems in the twenty-first century. It calls for increased investments in health, "empowerment" of individuals and the public, increased social responsibility for health and consolidation of infrastructure for health promotion.

Our thanks to the many people from all over the world who have contributed with papers, presentations and speeches to the success of the Jakarta Conference.

Dr Desmond O'Byrne  
Chief HEP, WHO

Dr Ilona Kickbusch  
Director HPR, WHO



### **Division of Health Promotion, Education and Communication (HPR)**

The special focus of the Division is to design and promote policies and programmes that:

- ▶ maximise the health outcomes of community settings such as schools, workplaces and cities;
- ▶ ensure the appropriate community health response to population ageing and increasing chronicity and disability;
- ▶ encourage healthy lifestyles and self-care throughout the lifespan; and
- ▶ secure advocacy for health through media relations and communications support.

### **Health Education and Health Promotion Unit (HEP)**

The overall goal is to provide assistance to WHO Member States which will enhance their capacities and develop infrastructures for health education and health promotion.

HEP acts within the framework of the Alma-Ata Declaration on Primary Health Care (1978), the Ottawa Charter for Health Promotion (1986) and the Jakarta Declaration on Health Promotion (1997), to achieve health for all.

Within the Five-Year Plan of Action, HEP sets the following interrelated objectives:

1. support for the development of policies for health education and health promotion;
2. support for the implementation of health promotion strategies in certain settings;
3. advancing methodology for health education and health promotion;
4. promote health through schools;
5. review and evaluation of health education and health promotion.

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**New Players for a New Era: Leading Health Promotion into 21st Century  
Fourth International Conference on Health Promotion  
Jakarta, Indonesia, 21-25 July 1997**

## **SPEECHES AND PRESENTATIONS**

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### **WELCOMING ADDRESS**

**Dr Uton Muchtar Rafei**



# **4th International Conference on Health Promotion**

*Theme: New Players for a New Era:  
Leading Health Promotion into the 21st Century*

**Jakarta, Indonesia, 21-25 July 1997**

Address by

**Dr Uton Muchtar Rafei**  
Regional Director  
WHO South-East Asia Region

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World Health Organization  
Regional Office for South-East Asia  
New Delhi  
July 1997





**Address by Dr. Uton Muchtar Rafei**  
**Regional Director, WHO South-East Asia Region**  
**to the 4<sup>th</sup> International Conference on Health Promotion**  
**Jakarta, Indonesia, 21 July 1997**

**Honourable Ministers,  
Mr. Chairman, Excellencies,  
Ladies and Gentlemen,  
Friends and Colleagues,**

As Regional Director of the World Health Organization's South-East Asia Region, of which Indonesia is a Member, it is a special honour for me to welcome you to the Fourth International Conference on Health Promotion: "New Players for a New Era". It is a meeting of minds that is as timely as it is urgent. In less than a thousand days-eight hundred and ninety-four days to be precise - we shall enter the year Two Thousand.

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That date has been an emotive magnet for us all over the past two decades. Sometimes it may have seemed like a distant horizon a mirage that never really got closer. Now it is upon us, and we have to face an uncomfortable fact: Our aspirations of Health for All are not yet reality.

Yes, we have made great progress. Science and technology have moved ahead with breathtaking speed. Societies in all parts of the world are in the process of great change, change which is bringing benefits to many, if not yet to all. The "New Era" has already begun. It is an era characterized above all by speed of communications. Information and knowledge can now reach more people more quickly and accurately than ever before in human history. Our job is to ensure that the right messages reach the right people. And the first of these messages is that: "Health is Everybody's Business". Our South-East Asia Region is home to one quarter of the world's population. It also accounts for 40% of all those who live in extreme poverty. While some now take mobile phones for granted, or air travel or the Internet, most are still mired in malnutrition, illiteracy and gender inequalities. While we see some success in increased life expectancy, falling infant mortality rates, and progress towards the elimination of leprosy and polio, we find ourselves facing new challenges like AIDS or re-emerging diseases like malaria, dengue, TB and plague which we once thought were under control. Lifestyle changes which



seem to bring material improvement are accompanied by increasing incidence of heart disease, cancers and diabetes - afflictions once associated more with the developed world

We can only keep up with the pace of change if we set out to master the tools at our disposal. The systems available today and developing for tomorrow, may provide the means to communicate as never before, but they have no inherent wisdom. It is up to us to develop that wisdom, and to channel it based on well-formed strategies, practical policies and imaginative partnerships for health.

In our Region, we can fairly say that health is moving up the political agenda, though it is not yet, perhaps, at the top. Next month the Health Ministers of our Region will meet to make a Declaration on Health Development in the next century: A Declaration based on health as a fundamental right of everyone; equity, solidarity, and social justice; and health as central to successful development. It will advocate steps to eradicate gender discrimination and to involve communities fully in their own health development. And it seeks the commitment of all sectors, public and private, in meeting the social and economic challenges of health. It seeks nothing less than the achievement of health for all by mobilizing all for health.

We are building support where it counts. Indonesia has shown the world how, with political will, health can become central to a nation's development. The national family planning programme is considered a model of its kind. From the centre of this great city of Jakarta to remote rural communities, you can see the smiling face of Bapak Presiden on giant billboards encouraging people to have their children immunized. National Immunization Days have developed into a major feature of our Region. Last December we achieved a world record in the number of under-five immunizations in a single day.

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This was the result of constant advocacy and imaginative intersectoral action: state and private sectors, NGOs and community volunteers, working together towards a well-defined goal, building trust and confidence that people can have a direct effect on their own and their children's health. We are building supportive environments with the Healthy Cities Initiative in several countries and plans are being prepared for three countries of the Region to join the Mega Country Initiative. We are expanding the scheme for health-promoting schools, and doing everything in our power to encourage controls on the use of tobacco, whose harmful effects are increasingly spreading to women and the young. In all of these and many other efforts we recognize that our eventual success depends on our ability to create and manage partnerships, between and among a wide spectrum of "new players".

We have to come down from our ivory towers forever. To live and work on the ground, where all people live. To live and work with all people as partners for health. Health is more than a medical or scientific issue. It is, quite, literally, *"everybody's business"*. That basic recognition is the true starting point for health in the twenty-first century.

This conference will be judged not by the high-sounding words used within, but by the actions it generates in the wider world outside: the world of the poor, the malnourished, the illiterate, the vulnerable, and the millions of victims of unnecessary disease. We have technical abilities as never before. We have technologies to overcome every barrier of distance and time.

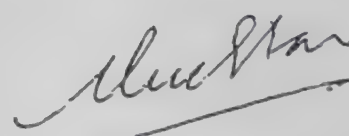
We still need the humility to accept that we cannot succeed alone. We still need to learn to respect the needs and abilities of others. We need to learn to share and not arrogate our knowledge to ourselves alone. We need to build trust. In a global village, like any village or kampong, there are no secrets any more. Everybody, in every community, has a role to play, based on mutual collaboration and consensus of what is best for all. Our task is to add our technical abilities to the common bowl for all to partake of at the same time doing our utmost to convince people of their vital part in improving their own health and that of their neighbours. We have to become better communicators.

We have to shed past habits of exclusivity of superiority of them and us. If we are to engage people in partnerships institutional or individual, private or public, great or small we have to meet our potential partners half-way. We have to address others in language they can understand, leaving our technical terminologies in laboratories where they often belong.

If we talk about "equity", we have to apply it to our own dealings, for successful partnership can only be equal partnerships for the benefit of all. We have to delegate in some part the authority the international community has invested us with. While insisting on health as a fundamental right, while positioning health at the centre of successful development policies, while doing all we can to promote healthy lifestyles in a fast-changing world, we must not forget that our authority is derived from the community too. Respecting others is the first step towards generating respect for oneself.

Excellencies, ladies and gentlemen we are living in exciting times. We have never had greater power to communicate to reach everyone everywhere. How we do it is the acid test of our strengths and abilities. The new players we seek for our new era are everywhere waiting. They are waiting for us to demonstrate how our noble ideas can be translated into action, how abstractions can become practicalities how health for all can finally become reality. We are on the threshold not only of a new century but of a great opportunity. Seizing the opportunity is what generating successful partnerships is all about. Let the opportunity of this conference be a partnership of many eminent and focussed minds seeking together ways to reach out across the world. And in wishing you success in this partnership of minds, may I also hope that you will find time to enjoy the unique hospitality, culture and warmth of the people of Indonesia.

Thank you.



Dr. Uton Muchtar Rafei





**New Players for a New Era: Leading Health Promotion into 21st Century  
Fourth International Conference on Health Promotion  
Jakarta, Indonesia, 21-25 July 1997**

## **SPEECHES AND PRESENTATIONS**

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### **LOOKING BACK...LOOKING AHEAD HEALTH PROMOTION: A GLOBAL CHALLENGE**

**Dr Ian Potter**





Looking Back ... Looking Ahead  
Health Promotion: A Global Challenge  
by  
Ian Potter  
Assistant Deputy Minister  
Health Promotion and Programs Branch  
Health Canada

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at the  
Fourth International Conference on Health Promotion  
Jakarta, Indonesia  
July 21, 1997

Revised: July 7, 1997





# Introduction

Dr. Soedirja, Minister Sujudi, Dr Nakajima, Dr Rafel, other distinguished guests, fellow delegates. It is a great privilege to be here at the Fourth International Conference on Health Promotion and to bring you best wishes from the people of Canada, from my department, and from the Honourable Allan Rock, our newly-elected Minister of Health.

Mr. Rock has asked me to personally convey his regrets at being unable to participate in the conference. Minister Rock, having just assumed his new position, has a number of urgent domestic issues that require his attention. He has indicated, however, that he is looking forward to hearing about the outcomes of this important event.

It is an honour that Canada once again has the opportunity to participate in a significant milestone in the progress of the modern health promotion movement. This year there have been many celebrations throughout the world celebrating the tenth anniversary of the *Ottawa Charter for Health Promotion*, which was born at the first International Conference in Ottawa, Canada. Since 1986, the Ottawa Charter has been translated into 50 languages. It has been used throughout the world as a basis for health planning, policy development and academic endeavours.

In Canada, we also had occasion this year to celebrate 25 years since the publication of *A New Perspective on the Health of Canadians*. This document was the first to suggest that environments, lifestyle and human biology were as important as health care in influencing people's health. It was also the first government document in the world to identify health promotion as a key strategy and policy for improving health.

It is therefore timely to take stock. This conference will assess the achievements in health promotion that have been made around the world and look into the future. The theme for the conference—*New Players For A New Era*—is also timely.

The world as we know it is in the midst of a global revolution in trade, politics, finance, communications, research, technology and the movement of people. As we become increasingly connected, we will need to build



alliances around common concerns. Threats to health resultant from environmental degradation, poverty and disease do not suddenly stop at national borders.

Many of the "new players" at this event come from developing countries. These countries are not new to health promotion. Indeed, since the Declaration of Alma Ata in 1978, they have used health promotion techniques under the banner of primary care to better the health status of people in their countries. Canada and other industrialized countries have as much to learn from their experiences as developing countries have to learn from ours.

In my time with you this evening, I'd like to do three things:

- First, to outline some of the things we have learned in Canada during the ten years since the creation of the Ottawa Charter. I will be brief; however, for those of you would like to continue a dialogue, there is a time on the program to discuss a Canadian case study.
  - Secondly, to speak to tonight's theme—the global challenges that are ahead of us.
  - And lastly to explore how we as partners in health promotion can address these challenges.
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In doing so I intend to take an optimistic view of the future, despite the severity of the challenges we face.

There is a story about two young brothers who were asked by their uncle to clean out a horse's stable that was filled to the brim with manure and old straw. One brother, who was a pessimist, complained loudly and found all kinds of excuses to get out of the job. The second brother, who was an optimist, happily started shovelling away. When his pessimistic brother asked him why he was so enthusiastic about the job, the young optimist replied: "Well I figure with all this manure, there has to be a pony in here some place!"

There is a growing body of literature suggesting that the young optimist will live a longer, healthier life. People know in their hearts how important it is to take an optimistic view in the face of great challenges. Recently, when we asked Canadians what factors have the greatest effect on their health, "(a positive) state of mind" ranked in the top five.

### Looking Back: What Have We Learned?

Like most other countries, Canada has gone through some painful reductions in government programming in order to reduce our national and provincial deficits over the last ten years. At the same time, we have undertaken a process of health care restructuring and reform. Health promotion as a way of working has continued to grow and evolve, particularly at the grassroots level. Despite a recession, we have witnessed the birth of a consortium of 12 Centres for Health Promotion at universities across Canada (two of which are WHO collaborating centres), the integration of health promotion into public health programs across Canada, some progress in the creation of healthy public policies and the growth of community action programs for children, youth, women, older adults and other groups.

In our efforts to improve health, we have in one sense, gone "back to basics" by putting more emphasis on the main determinants or "prerequisites for health" as they are called in the Ottawa Charter. This process culminated in the release of a document called *Strategies for Population Health* which was endorsed by the federal, provincial and territorial Ministers of Health in 1994. This document speaks to the growing body of evidence about what makes people healthy or sick.

We have learned that socioeconomic status is the single most important determinant of an individual's health. In countries all over the world, people with high socioeconomic status are healthier and generally live longer. But there is another dimension to this picture. When we look at the overall health of a whole population, the distribution of income and social status is, in fact, a more important factor than per capita income or what a country spends on health care. The narrower the spread of income in a given society, the higher will be its overall health status.



Other major determinants of health include social support, education, employment and working conditions, physical environments, biology, personal health practices and coping skills, healthy child development, health services, gender and culture.

We call our renewed emphasis on broad determinants "population health" because it emphasizes strategies that affect the whole population in areas that are outside of health care, while continuing with our work in health promotion and health care.

Over the last ten years, we have learned a fair bit about the importance of intersectoral collaboration as a tool for "healthy public policy". In preparation for a recent WHO meeting on intersectoral collaboration which was held in Halifax, the Canadian Public Health Association prepared an analysis of intersectoral collaboration in Canada. Their report concluded that effective progress could be made by alliances among a variety of sectors, at a variety of levels. In addition to health, key groups that need to be involved include the economic, environmental, education, employment and social service sectors. Voluntary, professional, business, consumer and labour organizations need to be participants along with governments at all level.

- 24 Building these kinds of alliances is a time-consuming, delicate but necessary process. Since improvements in health lead to improvements in productivity and quality of life, the health sector can serve a catalytic role in bringing other sectors together. At the same time, however, we must resist the temptation to make health the only goal. If we are to be successful at drawing other sectors to our cause, we must be sure that their own goals and agendas are addressed as well.

Canada's experience in implementing healthy public policies related to tobacco illustrates some of the difficulties that can arise when putting this strategy into action. We learned that a strong, sophisticated health alliance is required to balance the power and influence exerted by a giant, global industry. We learned first hand about the importance of price controls, agricultural alternatives, media advocacy and legislation to protect children and non-smokers. We learned about the difficulties there

are in balancing the rights of individuals and interest groups.

We have learned valuable lessons about other health promotion strategies as well. One of these is the need to ensure that “reorienting health services” toward an emphasis on health promotion and disease prevention becomes a reality, not just an empty slogan.

Canada’s publicly-funded, universal system of health care continues to be a priority for the federal government and the people of Canada. Canadians see a universal health care system as part of their national identity as caring and compassionate people.

At the same time, we have learned that investing in health care has limits in terms of improving the health of the population. Indeed, most of the factors that determine who will be sick and who will be well fall outside of the health care system. Pouring more and more money into medical care is not the answer.

## Looking Ahead: The Global Challenges

I’d like to turn my attention now to some of the major global challenges that all of us share and to explore the implications of these challenges to health promotion.

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Since the optimistic days of the Ottawa Charter for Health Promotion, we have witnessed a redrawing of the world’s political and economic map. Globalization—which is characterized by our increasing economic and social interdependence—can be viewed as a threat to the health of our populations, or as providing us with some major opportunities to work together for a healthier world.

1. **As the world becomes more connected, the nature of disease has also been globalized.** Infectious disease is no longer a concern solely for developing countries. AIDS and the reappearance of tuberculosis in many developed countries has taught us the importance of remaining vigilant in our public health and health promotion efforts to control and prevent infectious diseases. At the same time, improved health and



longevity in developing countries means that these nations now join developed countries in dealing with increases in chronic diseases such as cancer, heart disease, diabetes and osteoporosis.

Preventing and slowing down the progress of infectious and chronic diseases will require the use of information technology to build global information systems and networks. This will allow us to share what we have learned and to avoid "recreating the wheel".

Changing disease patterns and increased pressures on health care services have important implications for health promotion. Health care services must strive to become an integrated and cost-effective continuum of care that starts with health promotion and includes primary and continuing care in the community, acute care in hospitals, and compassionate care for the dying. This system must be accountable to the community it serves. We can no longer afford to spend large amounts of money on medical and health interventions that cannot demonstrate their relevance and effectiveness.

When resources are scarce, decision-makers require clear, timely and reliable evidence. Evidence-based decision-making depends on a solid base of research and the ability to translate research results into understandable language and choices.

- 26 Until now, this has been somewhat problematic for health promotion. However, in the ten years since the birth of the Ottawa Charter, the Canadian Institute for Advanced Research and others from around the world have amassed and synthesized the sizable evidence on the determinants of health. At the same time, the University of Toronto Centre for Health Promotion has led the way on consolidating the evidence on health promotion—what works and does not work. Like medical care, health promotion must be accountable to the people.
2. Some of the products and lifestyle habits exported to developing countries have a negative effect on health. International trade in tobacco and the associated advertising of tobacco products is one clear example. The world's consumption of tobacco has increased by 75%

over the past 20 years. Most of that increased consumption has occurred in developing countries where multinational corporations advertize their products as an inexpensive way to appear Western, sexy, adventurous and upper class. In the early 1990s, tobacco caused about three million deaths per year worldwide. By the year 2020, we can expect that number to rise to 10 million tobacco-related deaths, with 70% of those deaths happening in developing countries.

The tobacco battle in Canada has shown us that the combination of comprehensive approaches proposed in the Ottawa Charter is the best way to frame and manage tobacco as a public health issue. That kind of approach must now become a worldwide one. We must work together, to share what we have learned and to cooperate in research, program, and policy development.

3. Increases in development and trade that lead to overall increases in prosperity will have a positive effect on health in many countries. There is a danger, however, that increased competition in open markets may lead to a widening of the gap between those that "have" and those that "have not" within nation states. Increasingly, men and women with lower levels of education will lose out in the competition for employment. The stresses and strains of unemployment erode an individual's physical and mental health and have significant repercussions on the health of other family members.

An increased emphasis on cost controls as a way to compete in the global market has also influenced the nature of work. In some countries, it has led to increases in child labour. In my country and others, we have seen an increase in the number of "non-standardized", casual and part-time jobs, especially for young people. Even in countries as privileged as Canada, a job does not guarantee an escape from relative poverty.

Efforts to decrease inequities must pay increased attention to the roles that gender and culture play in influencing health. In practically all cultures, women's roles are viewed as subordinate to men's. And while women in industrialized countries live longer than men, their quality of life is often compromised by violence, low wages, double workloads, and isolation in old age. All of us must give explicit recognition to the



need for gender equity (for both women and men) in policies, programs, access to health care and research.

The Ottawa Charter suggests that equity and social justice are prerequisites for health. These values serve as a counterpoint to the competitive pressures of a globalization.

Studies with developed countries show that growing disparities in income have a serious detrimental effect on the health of lower income groups, even though their absolute income is higher than the average income in some developing countries.

We will need to advocate and implement social policies and health promotion activities that protect vulnerable people and empower them to be part of the solution. This is not an easy task, particularly when government deficits are high and resources are limited. I am convinced, however, that this is, both ethically and strategically, the right thing to do. The degree to which we are able to enhance equity within and between our borders will determine whether or not health for all can be attained.

- 28 4. The 21st century promises to be the age of the city. For the first time in history, more of the world's citizens live in **urban environments** rather than rural ones. The implications for health status are enormous. Too often, massive urbanization is associated with increases in violence, pollution, slum housing, feelings of isolation and threats to food security.

Our experience in the Healthy Communities/Healthy Cities movement provides us with some of the tools we need to thrive, not just survive in urban environments. The vision of a Healthy City (or Healthy Community as we call it in my country) was born in Canada in the early '80s. Cooperative work with WHO Euro led to rapid growth of the concept around the world. Today, there are over 1,000 cities and towns recognized by the global Healthy Cities Network. Canada has 330.

The Healthy Cities movement and other health promotion success stories in schools and workplaces point to the value of what is often



called the "settings" approach —reaching people where they live, work, learn, worship and play. They also confirm the effectiveness of public participation and community action as strategies that promote population health.

5. Invariably, threats to the physical environment land high on the list of a Healthy City's concerns. But **issues such as climate control and environmental degradation** affect the global community. Over the last ten years, the idea of sustainable, human-centred development has been gaining ground. All of us will need to make compromises at both domestic and international levels. Industrialized countries that consume high levels of energy must take the lead in encouraging lifestyle changes in their own countries. However, this in itself is not enough. We will need to ensure that big business and governments cooperate to implement and respect intersectoral policies that promote the global goal of sustainable, health-enhancing, human-centred development.
6. **Healthy child development** remains a global challenge that none of us can afford to neglect. Population health studies suggest that children who grow up in nurturing, loving environments become healthy adults who are full contributors to society. Childhood poverty, illiteracy, early school leaving, forced labour, poor nutrition, neglect and abuse are the seeds of anger, despair, adolescent suicide, adult illness and premature death.

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Urged on by non-governmental organizations and the public, federal, provincial and territorial first ministers in Canada have made a renewed commitment to improving the well-being of children and poor families. The National Child Benefit package provides for policies that will re-invest millions of dollars in Canada's children. This will be complimented by a Community Action Program for Children that includes community-based health promotion activities such as home visiting, food supplementation and head start programs for Aboriginal children.

Internationally, we have made great strides in recognizing the rights of the child. But in the face of new global trends, a clearer strategy for

action is now required.

7. The last global challenge that I want to discuss is the capacity of **new information and communication technologies** to improve health. These technologies can help bring together the evidence that governments and others need to make effective decisions in health. Distance learning, global surveillance, interactive health networks, human resource development, telemedicine, social marketing and health education are other potential uses of modern information technology.

Computers enable children to meet and talk with other children who are continents and oceans away. They help patients become knowledgeable consumers. They help isolated people share common problems and solutions. In Canada, we have found that teenagers prefer to learn and talk about sex education issues through the anonymity of cyberspace.

Last month, the Canadian government and the World Bank hosted the conference *Global Knowledge 97: Knowledge for Development in the Information Age*. Working sessions at that event looked at the global challenges and opportunities for knowledge, science and technology in health, sustainable development and global partnerships.

- 30 Again, however, there are some fundamental challenges in how we use information technology. We must ensure that privacy and individual rights are fully protected. In centralizing and cataloguing information, we must be careful that we do not lose traditional knowledge and the value of learning by experience and story telling.

Information technologies must be used to reduce inequities, not enlarge them. Building supportive environments for health must include policies and programs that share information technology both within and between our countries.



## In Conclusion

There is an old story about a well-known trader who used to cross the border between Turkey and Greece on the back of a donkey. Each time he returned with a sack full of jewels for which he always had legal trading papers.

When the border guards would ask him what he was up to, he would answer "I am a smuggler." The guards would search for contraband but they never found any.

Years later, the trader, who had become very prosperous, retired and moved to Egypt. One day, one of the customs officials met him there and asked: "Now that you are safely away from both Turkey and Greece, what was it that you were smuggling all of those years?"

"Donkeys." the trader replied.

Sometimes, like the border guards, we miss the obvious when it is right in front of us. We forget that public policies which invest in sustainable human health are as important to our future as traditional policies in economic development. We look for high-tech medical solutions when community action, social justice and skill development is what is really needed. We forget the power of the three-page Ottawa Charter for Health Promotion in favour of complex models and long reports.

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In 1995 and '96, the Canadian Public Health Association, with funding from Health Canada, carried out a large consultation process with over 1,000 stakeholders in health promotion and sectors such as justice, education and income support. They concluded that the values, principles and strategies outlined in the Ottawa Charter are as relevant today as they were ten years ago.

Ladies and gentlemen, it has been an honour to be with you this evening. Canada looks forward with eagerness to the results of this Fourth International Conference on Health Promotion. And I wish all of you a successful and productive meeting. Thank you.





**New Players for a New Era: Leading Health Promotion into 21st Century  
Fourth International Conference on Health Promotion  
Jakarta, Indonesia, 21-25 July 1997**

## **SPEECHES AND PRESENTATIONS**

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## **CHALLENGE IN HUNGARY AND EASTERN EUROPEAN COUNTRIES**

**Dr Mihaly Kokeny**





**PANEL:**      **Health Promotion, A Global Challenge, 21 July 1997**  
(4th International Conference on Health Promotion, Jakarta, 21-25 July 1997)

Challenge in Hungary and Eastern European Countries  
by  
Dr Mihaly Kokeny

Ladies and Gentlemen, dear Colleagues!

Considering the challenges of health promotion in my country, Hungary, and beyond our frontiers, in Central and Eastern Europe, let me recall the birth of the concept or even the impact of health promotion in the 1980's. The former monolithic state-socialist ideology and practice, characterized by patronizing, victim-blaming and wishful thinking was hostile to this approach. This makes the fact, that health promotion did not find its way into the region. Even in Hungary, where economy and social transparency showed advances, it was difficult to elaborate a community-oriented health promotion programme in 1987. However, this came paradoxically too late and at the same time too early. Too late because of the already deteriorated health status of the population and too early, because the basic political and economic conditions which are important from the point of view of a real health promotion concept, changed only some years later.

Evaluating the effect of the radical changes in 1990, there are four (4) major factors, which influenced the development of health promotion.

- 1) A new economic situation, the transition from a central planning system to a market economy, parallel to a narrowing purchasing power, a decreasing GDP, at least for the first half of the nineties, as well as open unemployment were not favourable prerequisites for health

promotion. Unfortunately, only a few private investors put an emphasis on introducing healthy workplaces.

2) Legacy also included the lack of a well developed civil society. Nevertheless, thanks to the setting initiatives of WHO, we did not have to start from zero point. Healthy cities, healthy schools did already exist, there were sporadic, NGO's from different type, so the main task was to find these partners and to try to channel their activities towards joint health promotion priorities.

3) The tradition of the overcentralized state administration has to be taken into account as well. Different sectors and disciplines are separated strictly, there is no organizational infrastructure for intersectorial cooperation. And to be frank, the early period of market economy did not support a positive trend in this field, as it led to a hard, sometimes ruthless competition between the sectors for government resources, instead of promoting their collaboration. There is also a trend to medicalize social and other problems, this being an easy way to slip out of responsibility and to push everything into the shoes of the medical care system.

4) Speaking about medical care, it was obvious that health care reforms could not be prolonged, new priorities had to be set, even under increasing financial pressure. Cutting the oversized hospital capacity, developing primary health care created political debates which pushed health promotion issues lower on the agenda.

Of course, in addition to our weaknesses and concerns, opportunities for the future should also be assessed. Let us point out only three (3) areas. In the first place, rapid political development

and stable democracy create tremendous possibilities for partners in health promotion. A better advocacy in the Hungarian parliament might result in a plenty of scope for health in the draft legislation of not-for-profit organizations or in a new health care act. The same applies to local decision making.

Another potential originates from the economic recovery of the recent year. As a consequence of decreasing living standards, high inflation people highlighted short term considerations in their life strategies. With the improvements, more and more families and citizens are seeking for long-term investments in money markets, in continuing education and so on. Health promotion groups should make a deal and exploit the situation by demonstrating that investments in health do make sense especially in a more efficient and accountable system.

As Central and Eastern Europe is being more involved to the European integration process, health promotion as such will be viewed as a condition for a flexible labour market and competitive workforce. A healthier workforce will not only contribute to better productivity, but will also generate fewer demands upon the health services.

Ladies and Gentlemen, ten years after the spirit of Ottawa is alive and becoming stronger in our countries. In Hungary, we have traditional partners for health, primarily those from the different healthy setting approaches. The next step could be towards the large, partly multinational enterprises, more and more of which are working now in our countries. Some of them are committed in sustaining healthy workplaces, as for example the respective system of Ericson in Hungary, but are also causing some problems with transporting advertisement of unhealthy lifestyles to the countries of CEE. Partnership for health with the private sector is



relatively new for us, but a lesson we have to learn, and the result of which might be fruitful not only for the people and the governments of our region, but also for the enterprises themselves.

I would like to finish by saying what I picked up first more than ten years ago in the international family of health promotion. Health promotion is not a medical business but a complex and comprehensive task of many different actors whose interests and commitment in health are being harmonized. Let us find during this Conference the ways to "health promotion in the twenty-first Century" through a partnership, through common thinking and acting towards a common goal, the somatic, psychological and social well-being of our people.









# **THINK HEALTH**

## **What makes the difference?**

**Address given by  
Dr Ilona Kickbusch  
at the  
4th International Conference on  
Health Promotion**

**Jakarta**

**21-25 July 1997**





# 1. Think health: what progress?

We know that poverty kills, that dirty water kills, that tobacco kills. We know that children thrive on love, that communities are strengthened by social cohesion and that educated and empowered women are a determining factor for the health of a society. Most of the people in this room would agree that the level of health of an individual, a family or any group is strongly dependent on social and economic factors. We have heard this theme echoed in the many UN Conferences, all of which have chosen health to be one of the benchmarks by which to measure progress in human development. The World Bank has stated recently: "*The underlying threats to good health.....are well known, and affordable solutions are frequently available.*" And most recently the communique issued by the *Denver Summit of the Eight* most industrialized nations has highlighted to need to take common global action on health, in particular on ageing and infectious diseases. It seems therefore that health is definitely on the political agenda, more so, than when the Ottawa Charter was adopted. Yet as the global equity gap widens the access to a healthy life seems further removed for the citizens of some parts of the world than 10 years ago. This documents that we have still not fully understood the vital link between health and development.

*The Ottawa Charter* listed both the "prerequisites for health" namely "*peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity*" and it outlined the strategies for affordable solutions. There is agreement among the global health and development community that it is not the lack of money that hampers progress - it is the lack of health governance. The *World Development Report* of this year (1997) calculates that the cost of eradicating poverty would be about 1 % of global income and no more than 2 to 3 % of respective national income. With the investment of this one percent a significant part of the global disease burden would disappear - freeing up resources to go beyond survival into creating healthier societies. The World Bank in its recent Sector strategy paper on "*Health, Nutrition and Population*" calculates global health spending to have been at about US\$2,330 billion in 1994, this is 9% of global GNP and makes health one of the largest sectors in the world economy. Middle and low income countries account for 11% of global health spending (US\$250 billion) - 84% of the worlds population lives in these countries and they shoulder 93% of the worlds disease burden. The World Bank expects a US\$9 billion a year increase in low and middle income countries. "*In principle this is enough money to pay for essential population-based preventive and curative services for the 900 million of the worlds poor who still do not have adequate access to these services.*"

And there is not just talk. The first action programmes are under way. The World Bank has significantly increased its lending in health and education and other development banks are starting to follow suit. The *UN Special Initiative on Africa* will cover 10 years and make available \$ 25 billion to co-ordinate joint UN action in the key areas of *education, health, peace, better governance and water and food security*. In addition private investment in Africa has grown in view of the economic reform measures launched in over 35 African countries, so that quite a number have growth rates between 3 and 6%, some even as high as 8%.

We are always faced with the dilemma whether to view the glass as half empty or as half full. Much progress has been achieved in health and development in the last 25 years - and our host country is no small example of this - but it is surely the mission of public health to remain



constantly vigilant and draw attention to what has not been reached and what threats to health could be minimized by exercising foresight. The US Institute of Medicine has stated this mission of public health with great clarity and simplicity:

*“Fulfilling societies interest in assuring conditions in which people are healthy”*

## 2. The risk transition and the new driving forces

Throughout the world the health hazards are changing. The World Health Organization Report *“Health and Environment in Sustainable Development”* which analyses progress five years after the Earth Summit, makes the helpful distinction between *“traditional hazards”* related to poverty and *“insufficient development”* and *“modern hazards”* related to rapid *“development”* that lacks safeguards, and to **unsustainable consumption**. The former are rather quickly expressed as disease: you drink polluted water and get severe diarrhoea. The latter are more difficult and complex: a cancer-causing chemical may pass through the food chain for months and years, manifest itself in a tumour only after decades and not be easily subjected to a simple cause-effect relationship. Even more difficult to grasp and measure in their effect are the problems related to **“unsustainable consumption”** where many health and environmental issues meet. Low and middle income countries do not have the choice anymore to first deal with the one set of hazards and then move to the next. While still grappling with many *“traditional”* infectious diseases they also face the challenges of AIDS, tobacco, pollution and new hazardous lifestyles. The conflict is that frequently growth in these societies is generated through the development and support of unsustainable consumption. Development therefore only means health to a certain extent.

42 **“Underdevelopment”** as well as **“unsustainable consumption”** are associated with factors of economic and social development which the progress report calls *“driving forces”*. It is these driving forces that create the conditions in which threats to health can develop or be averted. They include (according to the United Nations Research Institute for Social Development - UNRISD):

- the spread of liberal democracy
- the dominance of market forces
- the integration of the global economy
- the transformation of production systems and labour markets
- the speed of technological change
- the media revolution and consumerism.

These driving forces and the pressures they exert are linked to many different players, interests and sectors. The new dimension is the speed of change and the fact that many of the players are now global, as alluded to in the title of this conference: new global regulatory agencies such as the World Trade Organization (WTO), transnational companies, regional groupings such as EU or ASEAN, media conglomerates, global NGOs.

The impact of these driving forces applies as much to the physical environment as to the social environment and it affects health through both these channels. **Indeed health promotion must**



concern itself much more systematically with the interaction between physical and social environments at local and global levels. It must aim to grapple with the resulting disturbance of the social ecology of our societies and propose the organized social response in the form of salutogenic public health strategies.

### 3. Reinforcing the socio-ecological perspective of health

Building the *Ottawa Charter* on the firm foundation of a social model of health and highlighting the importance of sustainability and ecological factors already five years before the *Rio Earth Summit* showed foresight and is surely one of the main reasons why the Charter remains as significant as it is: as research and experience expand, its premises and strategic approaches are shown to be sound. Contrary to many others I do not think that we need a "*health promotion theory*". I consider health promotion a theory based process of social change contributing to the goal of human development, building on many disciplines and applying interdisciplinary knowledge in a professional, methodical, and creative way. I am also not particularly convinced that the application of clinical terminology to health promotion - such as *evidence based* - is the right way to go.

In my view health promotion is "*determinants based*". With this I mean to express that it bases its strategies on best knowledge how health is created and how social and behavioural change is best effected. It aims to maintain health as a resource and prioritize investment in health through the following four questions:

**What creates health? Which investment creates the largest health gain? How does this investment help reduce health inequities and ensure human rights? How does this investment contribute to overall human development?**

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This is how the *Ottawa Charter* was constructed. We know that certain social factors improve and strengthen health (such as social support), we know that others endanger it (such as lack of self esteem) and we know that this is usually a long term and cumulative process, patterned by many interdependent variables. And whereas we can aim to build models of influence, they will never quite reflect the reality of peoples everyday life and decision taking, which is further influenced by their values, norms, emotions and aspirations. In my view "*health promotion outcomes*" are measures that show that the determinants of positive health have been strengthened within a given nation, community and/or setting. **They are those elements which contribute to the health, quality of life and social capital of a society. And they can only be "produced" by an organized, partnership based community effort.** This is a significant shift that looks not only at how other sectors produce health, but also at the wider societal contribution of the health sector. The concern of societies will increasingly be social not physical health.

Take, for example, an *Index of Social Health* which has been developed in one of the largest WHO Member States. It is based on 16 measures including *infant mortality, teenage suicide, dropout rates, drug abuse, homicide, unemployment, poverty among the elderly*. The index ranges between 0 and 100. From 1970 to 1992 the index showed a decline from 74 to 41. The World Development Report 1997 reports that in 35 countries the human development index had declined. This means that the overall well-being within those societies had decreased



significantly. No one agency or sector can respond to this, indeed it needs a new type of health governance to respond. Some authors have proposed to speak of a ***socially toxic environment*** which affects the most vulnerable populations first and worst: in particular children and young people. What a paradox if those that are to benefit from sustainable development in the next generation are deeply hurt socially as they grow up. Childhood needs supportive environments for its development and it is not incidental that *child development* ranks first in those policies and strategies that attempt to deal with determinants of health.

We are still at the very beginning of how to measure socially toxic environments and their effect on health and how to measure human responses (at individual and community level) to environmental stressors - particularly because of the cumulative and often long term effects. The Koster health project in Sweden is trying to do this as part of their contribution to Agenda 21. Obviously inequity is a component as are violence (real and virtual), fear, lack of security and trust. Somehow Joe Camel belongs here as does the marketing of alcopops. Creative measures include *cultural indicators* such as developed at the Annenberg School of Communications which indicate that the average American child will have witnessed more than 8 000 murders and 100 000 other violent acts on TV by the time he or she leaves elementary school. Another approach is to measure social capital, which is defined as "*the processes (features of social organization) between people which establish networks, norms and social trust and facilitate co-ordination and co-operation for mutual benefit*". Those involved in social epidemiology and salutogenic research have known for long that coherence, belonging, social support, networks, religious ties make a difference to health, indeed that social bonds, love and caring (giving as well as receiving) seem to be a protective factor even under the worst of circumstances. What we know less about is the influence of the many new factors related to media, new information technology, advertising, marketing - **in short the marriage between the information and the consumer society**. And we know even less about the social impact of these changes in the low and middle income countries. What does this mean for the 2 billion teenagers we will have on this planet by the year 2001? Are their life options widening or being reduced?

One of the many reasons we need partnerships with the communications industry, the lifestyles industry and the health care industry is to explore these kind of issues jointly - because the joint exploration can mean the **development of joint values, a joint social responsibility and joint action**. The claim that sustainability means to not leave our children a world that is worse than the present applies to social health as much as it does to trees and whales. For health promotion this means that we are challenged to expand the *settings approach* in several directions:

- beyond organisational settings and organisational development to *social spaces and social development* - such as childhood, being female and growing old,
- towards understanding the full impact of the *information technology revolution as a major driving force* and its effects on human development and health,
- towards *marginalized and excluded populations*, their settings - slum dwellings, remote regions - and their health and social needs
- towards a better understanding of "social toxicity" and "social capital" and a revisiting of health promotion programmes with this perspective.

In short, we need to widen the understanding of supportive environments as expressed in the Ottawa Charter.



## 4. Health Literacy

I would like to propose that a key challenge for health promotion lies in **combining strategies for building social capital with strategies that build intellectual capital for health**. We know that education is one of the strongest predictors for health - and that women's education is one of the strongest predictors of family and community health. Increasingly literacy programmes are using health issues as their entry point because of its high relevance to peoples everyday life. Under the ongoing conditions of rapid change traditional health knowledge does not suffice and in all societies there is a constant need for new health knowledge - in view of new hazards and risks, new treatments, new ways to maintain health. Health learning becomes a necessary component throughout the lifespan - a productive factor so to say: as society changes, as ones own living conditions change, as ones body changes. In the new version of the health promotion glossary we have introduced the term "**Health literacy**", meaning it to widen what in the Ottawa Charter we had called "developing personal skills": *information and knowledge on health, understanding the social components of health, ability to negotiate the environment, understanding and weighing risks of individual and social behaviour, coping skills, caring skills, skills to use the health sector, shift from fatalistic acceptance of health problems towards implementation of health knowledge.*

The increasing importance of health literacy for all societies must lead us to explore new places of and for learning, new methodologies and new vehicles. Participatory learning through the settings approaches is one - the use of the communications media and information technology is another. Community radio, soaps for health, health on the INTERNET, social marketing media advocacy using the many channels of adult learning and creating alliances with the communications and the adult learning community opens up increasing possibilities that we must explore more systematically and relate to the social gradients in health behaviour. Can health literacy balance the social gradient? What kind of knowledge is it that makes the difference?

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## 5. Governance for health

Health promotion as a social change and development strategy sits uneasily in any sectoral view of the world - it sits particularly badly in a health sector that focuses on service provision and that is increasingly dominated by an economic rationale. The world of health policy - with some notable exceptions - is still far removed from shifting the priorities from health services to investment in health. And we should not fool ourselves by jumping on to the economic bandwagon by advertising that health promotion would provide the most cost-effective solutions. Insisting on health promotion strategies as outlined in the *Ottawa Charter* in a climate of short term cost effectiveness is not for the faint of heart as many of you here will testify. There is never enough money, never enough support, never enough time. The examples documented for this conference show: it can be done, frequently through new ways of working together in partnerships, across sectors and across public/private boundaries. But still we must reinforce our effort for investments for health and development.

Yet we need to state clearly that the present traditional sectoral forms of policy making and public administration do not fit the integrated nature of many of the problems societies need to solve in the face of change. An integrated approach to health within government is needed and



increasingly there are suggestions that measures of health and wellbeing become the benchmarks against which to assess the overall development level of a society rather than focusing on narrow economic indicators. Health status is a very sensitive indicator - major shifts can be mapped within short periods of time in both directions. For example, within just 30 years Japan's life expectancy has grown to be the longest in the world: 76 for men and 82 for women. Other Asian countries are moving in a similar direction, our host country among them. In contrast, life expectancy in Eastern Europe fell consistently within the same period to finally plummet at the end of the eighties, with first signs of increase in some countries in the last couple of years. Data show us very clearly that the respective health systems or health expenditures do not correlate with the magnitude of the change. Indeed we can see in some societies that health care expenditures can become unsustainable, as they take resources away from investments in health. The Ottawa Challenge to reorient health systems now means establishing criteria for sustainable health systems - systems that aim to produce health as well as providing lifespan care. The health system must as much be subject to health impact statements as should other sectors.

The increase in health status has been highest when there is a combination of factors; *economic growth, equitable distribution of income, high investment in education, and social cohesion*. The futurist Alvin Toffler predicts that in 2020 the world's healthiest and longest living populations will be in Asia. Yet first clouds are appearing on the horizon: not only the slowing down of the extraordinary economic boom period, but an increasing discussion - as in Japan for example - about the loss of social cohesion, which in turn will have a significant effect and be influenced by an unprecedented situation for any society: by 2015 one in four Japanese will be 65 or older. An article in last week's Herald Tribune mirrored the concerns faced by Japanese society today: "A fundamental question for Japan is whether it can move to a more market oriented system without disrupting the sense of community that for centuries has been at the root of Japanese society.... Some Japanese wonder whether (these developments will lead to) ....a society that values wealth more than cooperation and social responsibility." Will the successful outcome for one generation constitute both a social and financial crisis for the next? When do we see the cut-off points? What affects the shift? When does economic growth turn into unsustainable consumption?

Since the health care reform debates in many countries are dominated by issues of financing and pushing governments to shed many of their functions and responsibilities one key function has remained very much in the background: *the socially integrative role that governments play in maintaining a common purpose and protecting the public good*. Economically speaking this belongs to the "large externalities" which are usually seen to be a wide range of measures that support the public good, for example accepted public health measures (clean water, food safety, etc.). They need to be expanded to encompass their social nature. Increasingly, we are learning that just as the market does not fully regulate itself except in economic textbooks so does "social capital" not just exist of its own accord. A tendency has been to downplay or downright cut the role of the state in service provision - but we do not yet know the consequences of this privatization and the lack of social cohesion and common purpose this might entail.

It is this social vacuum which "governance" must help to fill with increasing the interactions between the state (and indeed why not health promotion agencies) and society by bringing together the range of players that have an interest in functioning and active communities. Governance initially developed at the city level and as a horizontal coordination between multiple social agents: at its best it is democratic, participatory and accountable to the



stakeholders. The *Healthy City approach* is a model in bringing together different stakeholders and increasing participation in decision-making and only those cities that have understood this to be at the essence of the project have truly succeeded.

Most recently the new Minister of Public Health in the United Kingdom has put forward the proposal to create "*Healthy living centres*" throughout the UK. Their common purpose would be "*to promote health, helping people of all ages to maximise their health and wellbeing*" and would be targeted at groups who experience worse health than the average or who are not readily attracted to existing facilities for health. This is very similar to the brief developed for "healthy city centres" aiming to bring together aspects of social, physical and environmental health. Increasingly, strategies need to be of this integrated nature - which means that they will need to be financed in new ways - since they cut across accepted sectoral budgets.

Models exist in using money from national lotteries, creating special funds and foundations and in dedicated taxes, in particular from tobacco sales. One of the most interesting approaches has recently been launched in Brazil for the financing of health and social services, but it is also the approach that has met with most difficulties and opposition.

At the end of 1995 the then Minister of Health of Brazil presented to Congress the proposals for a taxation equivalent to 0.2 on all financial transactions going through the banking system in Brazil (public or private). It was approved in 1996 and was expected to raise around US\$ 5 billion to supplement the health budget, by June 1997 it had become clear that the amount for the year would exceed US\$ 7 billion. Originally this money was to be used for priority areas, including health promotion - in practice it has been used to minimise the US\$ 1 billion deficit of the health sector. The future of this law is unclear, the opposition is great from those for whom it means greater accountability of financial transactions, from those who are opposed to the "redistribution" effect and from those who oppose that the money pays for problems that have arisen through other political crises. Yet this example brings to the fore what the discussions about environmental taxes and value added taxes are increasingly bringing to the debate: **that "public goods" such as "health" which benefit the whole of society need to be financed in new ways that reflect the overall societal responsibility for and benefit of health.** An idea that has also come forward is to introduce a levy on expenditures for marketing and advertising, which would serve health promotion and health literacy, so as to move away from a simplistic "sin tax" concept. This is interesting to explore given the fact that US\$ 260 per capita globally are spent every year on packaging and marketing products, while many countries have to make do with US\$ 5 per capita to spend on health.

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## 6. The interdependence

"*Think globally is good bumper sticker advice, but it is a daunting task.*" is a sentence I read recently. All the more so because *globalization* is not really global. Transnational business activities are highly concentrated and the majority of the world's population is still outside of this system - yet the processes of globalization are changing the character of nations and the quality of life everywhere. It is by nature intrusive, whatever its effects. With the lack of decision making structures and law enforcement at the global level is another level where governance has worked as a set of interacting guidance and control mechanisms. Peace building, human rights



and the environment are usually cited as examples - indeed the Earth Summit of 1992 is seen as the turning point in global governance, putting it firmly on the map. The *World Trade Organisation* is seen as the most far reaching and powerful of these new governance structures, probably followed by the *global climate convention* and hopefully the *global convention on the rights of the child*, which has now been signed by all but two countries. WHO is presently exploring the possibility of a *global convention on tobacco*. We will clearly see these types of agreements increasing, sometimes undermining national standards, sometimes going far beyond them. New norms, new standards, new rules of conduct, accountability and decision making need to emerge from this new situation. Peace-building and development policies play an increasing role in the health agenda - drug growing and trafficking from poor countries to the more affluent parts of the world is as much an issue as tobacco subsidies in the European Union and export of cigarettes to developing countries. They illustrate the interdependencies in all directions. Health promotion should position itself firmly in this context of global health governance.

In this context too financing proposals speak of **global taxation for servicing the needs of the global neighbourhood** - environment, health, education and and poverty reduction. The OECD development assistance committee declared their support for halving income poverty by 2015 and achieving education and health for all by that date. In the global economy of US\$ 25 trillion the ratio of the poorest to the richest is 78 : 1 in 1994 compared to 30 : 1 in 1960. The most straightforward approach would be taxing all currency exchange transactions (US\$ 1 trillion a day) at 0.003% or less. Other proposals include a "tax" on the transaction of those industries that benefit most from a peaceful world: travel, transport, communications. A tax on mobility - for example on airline tickets - has been proposed regularly. Think of the scope of tourism: it is the worlds largest industry, it has 10% of the global work force, 10.5% of world GNP, 10% of all consumer spending. And it is dependent on health: safe food and water, safety from epidemics and infectious diseases, hygiene standards to name but a few. Globalization offers great opportunities but only if it is managed more carefully and with more concern for global equity.

Perhaps what is most worrying of all is *the lack of governance on behalf of people who are neither rich, educated, skilled* as the word is understood in the global marketplace - that is most people. Health advocacy must become much more powerful and citizen driven and human rights oriented. Step by step the globalization from below is widening and the global summits have significantly contributed towards this -the NGOs are beginning to occupy global public space. They speak up for a global civic ethic of rights and responsibilities and call on public accountability. Health and environmental impact statements are part of this development. This is where the new information technology does make a significant difference in given ordinary citizens a voice and allowing advocates to communicate without having to buy expensive airline tickets. All kinds of networks are forming and I hope that the WHO networks will also contribute to this new global web for health that is in process of being generated.

## 7. Outlook

Which is the world's healthiest country? Is it the one with the highest life expectancy? Is it the one which ranks highest on the human development index? The one that has the highest health budget? The one that has the least social gradient in health? Is it the country with the lowest burden of disease?

From a global perspective I would plead for an accounting system similar to the one that ranks Costa Rica as the world's healthiest country. This ranking is based on a new proposal of linking health and ecological indicators in a measure called the "**ecological footprint**": it calculates the ratio of life years produced to ecoproductive land/resources consumed. I quote:

*"By 1991 Costa Rica delivered a life expectancy of 76 years to its citizens, compared with an average of 77 years for the world's 22 richest countries. It did this on a national income of US\$ 1,850 per capita, compared with an average of US\$ 21,050 for the 22 richest nations. ....In general poor low-consuming societies (with a high health status) are characterised by a high level of literacy and independence among the female population and high levels of investment in health and education compared with other countries in their income bracket."*

This puts the high life expectancy in rich countries into perspective and it shows that policy makers in developing countries do have a choice. Could they maintain the same high health status while consuming less of the world's resources? Is their health sustainable? What does this mean for low and middle income countries as they develop further and set health expectancy as a goal? Can we continue at a level of national and international governance to continually only look at part of the pie? A futurist has proposed recently that each level of governance should have "*a department of consequence*" which informs the policy makers and the citizens of the costs and benefits of investing in different sectors and in different ways. For each one of us individually health probably means those components spelt out in the Human Development Report: **a long healthy and creative life, a decent standard of living, freedom, dignity, self esteem and the respect of others.**

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The poverty of one quarter of the world's population is more than income poverty: it is the denial of choices and opportunities for living a tolerable life. That is basically what WHO means when it speaks of health security and health as a human right. I hope that this Conference contributes to that global conscience with a strong will to act on the factors that create or destroy health.

We need to work with the **global paradox**, meaning both more action on the social health issues at the local level **and** the global level. This means to

- harness some of the *new driving forces* for health,
- position health promotion as much part of the *social and human development agenda* as part of the health agenda,
- position health promotion as a key element of *good health governance* - thus opening new avenues for health governance, financing and accountability, and finally
- to fully understand the changes in the global system of health production and to work towards a more systematic *global response*.



All this can only be done in partnership, in facing conflicts and negotiating solutions. It is the ongoing challenge of a new public health. It is truly a new common agenda, because just as with communicable diseases: no longer is my health safe if your health is not safe, violence is as much an epidemic as is tobacco or tuberculosis. Health is a public good, a global commons, a global resource. It is a process in which we continually strive to move forward. It is a journey of discovery as expressed poetically by Oscar Wilde:

*"A map of the world that does not include Utopia is not worth even glancing at, for it leaves out the one country at which humanity is always landing. And when humanity lands there, it looks out and, seeing a better country, sets sail. Progress is the realisation of Utopias."*

In this sense - let us move health promotion into the 21st century.

## References

The Commission on Global Governance (1995), A Call to Action. Summary of Our Global Neighbourhood. Geneva.

Cox, Eva (1995) A Truly Civil Society, 1992 Boyer Lectures, Sydney: ABC Books.

Garbarino, James (1995), Raising Children in a Socially Toxic Environment. San Francisco: Jossey Bass.

Human Development Report 1997 (1997). Published for the United Nations Development Programme. New York, Oxford: Oxford University Press.

Kazancigil, Ali (1998) Governance and Science: Market-like Modes of Governing Society and Producing Knowledge in: International Social Science Journal, no 155. March (forthcoming)

Stossel, Scott (1997), The man who counts the killings. In: The Atlantic Monthly, May, pp 86-104.

Putnam, R. (1993) Making Democracy Work: civic traditions in modern Italy. New Jersey: Princeton University Press

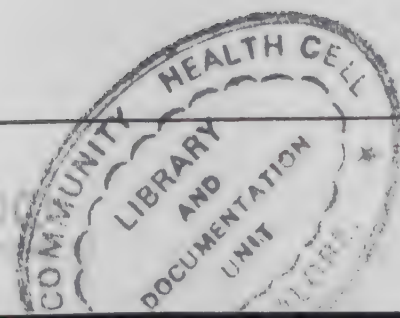
Speth, James Gustave (1997), Global Governance for Sustainable Development. Speech held in Rio de Janeiro, 18 March 1997.

The United Nations: Policy and Financing Alternatives. (Eds) Cleveland, H., Henderson, H., and Kaul, I., The First Report of the Global Commission to Fund the United Nations. New York: Apex Press.

The United Nations Research Institute for Social Development (UNRISD) (1995), States of Disarray: The social effects of globalization.

Wilkinson, Richard G., (1996), Unhealthy Societies. The Afflictions of Inequality. London/New York: Routledge

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Fourth International Conference on Health Promotion  
Jakarta, Indonesia, 21-25 July 1997**

## **SPEECHES AND PRESENTATIONS**

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## **GLOBAL HEALTH TRENDS AND HEALTH POTENTIAL**

**Dr O. Shisana**



# GLOBAL HEALTH TRENDS AND HEALTH POTENTIAL

By Dr O Shisana  
Director-General of Health: South Africa

## INTRODUCTION

In the last five decades, significant advances have been made in health - life expectancy has increased, infant mortality has dropped and diseases like small pox have been eradicated. Public health professionals probably agree that we now are able to handle public health problems better than before the introduction of scientifically determined public health interventions and the accelerated improvement in the standard of living. We also will probably agree that there are still major regional, country and within country disparities in access to these proven public health interventions and the improved standard of living.

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In many parts of the world, millions of men, women and children have not benefited significantly from these changes. The conditions which militate against people in their quest to be healthy include:

- poverty;
- war, violence and displacements of large populations;
- drought and famine;
- structural adjustment programmes, heavy debts and a lack of resources;
- unemployment, rapid urbanisation and population growth;
- infectious diseases;
- inadequate access to essential services and
- illiteracy.



In this paper we will look at the some of the successes achieved in health, some of the challenges that we still have to address and attempt to provide an analysis of these trends.

## **SUCSESSES**

### **Life Expectancy**

Life expectancy in 1950 in developing countries was 40 years. By 1990 it had risen to 63 years. However, 50 countries in the world have not achieved the target of life expectancy of 60 years or more. Of these 37 (74%) are in Africa (*World Health Report, 1996:12*)<sup>1</sup>.

### **Child Mortality**

56 Since 1950, child and infant mortality rates have been greatly reduced. In 1950, 28% of children died before age 5 years and by 1990 this figure has reduced to only 10%. (*World Development Report, 1993:1*)<sup>2</sup>. Sub-Saharan Africa showed the slowest improvement in the rates of child mortality. Child mortality is affected by household income, food security; water and sanitation, immunisation and the level of education of the parents. The greatest declines in child mortality were in the developed countries (66%) and lowest for the least developed countries (30%) (*World Health Report 1996:14*)<sup>3</sup>.

### **Infectious diseases**

The improvements in living standards globally have led to fewer infectious diseases. A huge victory in the control of infectious diseases was the eradication of small pox through the cooperation of all countries.

Another success in the control of infectious diseases is the dramatic increase in the proportion of children immunised against the six major childhood diseases. The proportion of children immunised has increased from 5% in 1974 to over 80% in 1995. (*World Health Report, 1996*)<sup>4</sup>. Immunisation against diphtheria,

pertussis, tetanus, measles, tuberculosis and polio has saved millions of children from disability and death from infectious diseases. However 25 countries globally, 19 (76%) of them in Africa are still reporting a coverage below 50% for all six vaccines (*World Health Report, 1996:71*)<sup>5</sup>.

Africa has launched the "Kick Polio Out of Africa" campaign and hopefully polio will be eradicated from this continent in the not too distant future. Globally there have been 85% fewer cases reported since the launch of the eradication effort (*World Health Report, 1996:30*)<sup>6</sup>.

The prevalence of leprosy has been reduced by 82% worldwide over the last 11 years and 21 countries have been declared free of drancunculiasis (guinea worm disease)(*World Health Report, 1997: 24*)<sup>7</sup>. The last decade has seen fewer cases of measles and neonatal tetanus and as a result of this control of infectious diseases, child mortality has fallen in many parts of the world.

### **Water and Sanitation**

The percentage of rural populations with access to safe water increased from 13% in 1970 to 61% in 1990. This will result in a decrease in the incidence of waterborne diseases. Sanitation has also improved for many of the world's populations. Access to adequate sanitation increased from 11% to 36% (*World Health Report, 1997:121*)<sup>8</sup>.

### **Health Services**

Although health services play a small role in general improvement of the health status of populations, it is important to note that without these services we could have not prevented at least 5 million annual deaths resulting from small pox, and 5 million annual deaths due to diseases prevented by immunization (*World Development Report, 1993*)<sup>9</sup>. Moreover, health service facilities provide an avenue for promoting health such as family planning, health education to prevent smoking, excessive alcohol consumption, prevention and treatment of diarrhoea, etc.



### **Fertility**

There has been a significant drop in fertility globally. Women have on average 3 babies as compared to 4.7 in 1970 (*World Health report, 1997:10*)<sup>10</sup>. Generally this drop in fertility could be attributed to the greater use of contraception and a later age of first pregnancy. The lowering of the fertility rates is not uniform. While women in industrialised nations have an average of 1.8 babies, women in the least developed countries have an average of 5.6 babies (*World Health report, 1997*)<sup>11</sup>.

Many countries are undergoing a demographic transition. While in developed countries this means a growing older population, developing countries have increased numbers of children under the age of 15 years. It is estimated that almost 30% of the world's population is aged between 10 and 24 years and 83% of all the world's young people live in developing countries (*WHO, 1995:10*)<sup>12</sup>.

### **Move towards democracy and peace**

In the last few years, we have seen countries moving towards democracy and peace. Often, the move towards democracy is seen as one of the most health promoting event to take place. For many, peace means time to address the basic needs of clean water, sanitation, access to health services in contrast to needs for security.

### **CHALLENGES**

While there have been tremendous improvements in the health status globally, there are huge disparities in health status between and within countries, which present challenges to the global community and governments.



### **Aging population**

In many countries people are now living longer, leading to an increase in the proportion of the elderly population. In 10 countries, one out of five persons will be elderly by the year 2020, according to the *World Health Report (1997:121)*<sup>13</sup>. The longer one lives, the greater the chances of developing chronic diseases such as cancer, hypertension, heart disease, diabetes, etc. These diseases require continued treatment or medication for maintenance. In many countries, medicine cost as a proportion of health care costs is very high and increases at a faster pace than other health care cost components. Many countries face the challenge of having a greater burden of chronic diseases as well as having a huge burden of infectious diseases.

There have been increases in the number of deaths from cancers, heart disease, circulatory diseases and other chronic diseases, especially in developing countries with the adoption of habits of smoking, excessive alcohol consumption, sedentary lifestyles and diets high in fats (*World Health report, 1997*)<sup>14</sup>.

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### **Emerging and Re-emerging infectious diseases**

With the growing number of poverty stricken people in the world, we have seen the re-emergence of disease we had thought to be controlled by advances in medicine. We are also seeing the emergence of new disease like AIDS which is taking its toll on the economically active section of our societies

### **HIV/AIDS**

In 1993 WHO reported that by the year 2000 about 26 million individuals will be infected with HIV (*World Development Report, 1993:99*)<sup>15</sup>. Now, with only three years to go to year 2000, 22,6 million people are estimated to be already living with HIV/AIDS; this figure is growing by more than 3,1 million persons per year (*World Health Report, 1997*)<sup>16</sup>. At this rate, 32 million individuals, 6 million more than predicted only 3 years ago, will be infected with HIV. The

impact of this disease on the economy, children, families and on society cannot be underestimated.

This pandemic has spread to every continent. Despite the attempts at finding a cure, vaccination or drugs to control HIV/AIDS, the greatest challenge to humankind is posed by this disease. This disease could undermine the development programmes of most countries as it is the economically productive section of the population which is most affected. The control of the disease is bound up in the empowerment of women, the transfer of life skills to young people as well as a commitment from all sectors of the community to work together towards the control of the disease.

### **Tuberculosis**

WHO estimates that 7.3 million new cases of tuberculosis occur every year in the developing world and 2.7 million deaths occur annually due to TB. It was believed that TB was in decline or at least stable up to about a decade ago. In the past decade, there has been a dramatic increase in notifications of TB throughout the world. This reemergence of a disease, thought to be under control, has put a severe strain on the health services of many countries (*World Health Report, 1997*)<sup>17</sup>.

### **Malaria**

Malaria has been defying all attempts at control in Africa. Control measures have become increasingly ineffective over the past decade and more and more of the world's population is now at risk. Each year there are between 300 - 500 million new cases of malaria resulting in 1.5 -2.7 million deaths. Malaria is ranked as the seventh leading cause of death in the world. Ninety percent (90%) of cases are to be found in Africa (*World Health Report, 1997:122*)<sup>18</sup>.



## **Ebola**

The Ebola virus is one of the most pathogenic viruses known to science, causing death in 50 - 90% of cases. There have been 1054 cases and 756 deaths attributed to this disease since the discovery of the virus in 1976. Human cases of Ebola have only been identified on the African continent but with the ease of modern travel the potential is there for the eruption of this disease anywhere in the world.

## **Substance Abuse**

Many people around the world are changing their lifestyles. Rapid urbanisation and the problems of adapting to industrialisation are having their effects on communities around the world. The changes in lifestyle lead to modification in diet and behaviour which affect health status and the types of diseases to be found in a country. Unfortunately, the changes in lifestyle lead to different coping mechanisms adopted and this has partially lead to an increase in substance abuse globally.

### **smoking**

- △ Despite the considerable publicity given to the dangers of smoking, sizeable proportions of the world's population continue to smoke. This could be attributed to the addictive nature of tobacco and the aggressive advertising of tobacco companies. As the rate of tobacco use declines in the developed world, it increases in the developing world where tobacco companies have seen a unique opportunity to operate with fewer restrictions.

Tobacco related deaths amount to 3 million annually. It is estimated that in the 1990s, 30 million people globally would have died from a tobacco related illness (*World Health Report, 1997:61*)

<sup>19</sup>. Yet, the number of people who smoke, especially in the developing world, continues to increase. In China 61% of males aged 16 years and older are smokers.



The new agreement reached between the government and the tobacco industry in the United States will see tobacco companies targeting poorer countries who do not have tobacco control measures in place.

#### **illicit drug use**

- Δ There is also an increase in the use of narcotic drugs globally. Drug trafficking has become a problem for most governments in both developed and developing countries. While there has been extensive research into illicit drugs used in industrialised countries such as cannabis, heroin and cocaine, there is very little research into drugs widely used in many developing countries.

#### **alcohol use**

- Δ In most industrialised countries alcohol is accessible to everyone. The abuse of alcohol has enormous social consequences in both industrialised and developing countries. Road traffic accidents, violence (including domestic violence and crime) and abuse of children has increased with the increase in substance abuse.

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### **Nutrition**

Besides the changes of diet referred to earlier, there are still too many people who do not have sufficient food to ensure a normal work capacity and an adequate immune response to infectious diseases. Nutritional disorders are also factors in the causation of chronic diseases.

Reports show that there were large increases in the number of children aged under five years in South Asia and Sub-Saharan Africa who suffer from protein energy malnutrition (PEM). Macro-nutrient malnutrition is also more widespread.

Anaemia affects mainly women of reproductive age. It is estimated that 50% of women in developing countries are anaemic (*World Health Report, 1997:51*)<sup>20</sup>. The prevalence is highest in South Asia. Globally it is estimated that 2 billion people are anaemic and 3.6 billion iron deficient.

Iodine deficiency disorders (IDD) accounts for a great deal of illness and disability. The highest prevalence is in Africa, the Eastern Mediterranean, South East Asia and the Western Pacific.

**Intentional and unintentional injuries**

Violence in all its forms has increased globally and has had widespread and considerable repercussions on personal and community health and the delivery of health services. The large numbers of maimed and injured people place an additional demand on already overloaded health services. Other consequences of violence are the lack of safety of health workers, closure of health facilities and the disruption of essential services such as water supply, sanitation and refuse removal, which add to the strain on the delivery of health care.

Violence affects mostly women and young people. During 1993, 8% of total deaths globally were due to intentional or unintentional injuries (*World Health Report, 1997:63*)<sup>21</sup> and of these 300 000 were murders. Most of the deaths occurred in the developing world.

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Violence, especially sexual violence against women and children (girls more than boys) has increased.

**Burden of disease**

The most frequent diseases in the world are listed below. The incidence of these diseases is high, but the high incidence does not necessarily imply high mortality.

**Table 1: Global Health Situation: Selected Incidence Cases: 1996  
Estimates**

Diarrhoea (including dysentery)	4 billion
Acute lower respiratory infection	394 million



Malaria	300 million
STD – Trichomoniasis	170 million
Occupational diseases	160 million
Occupational injuries	125 million
Mood disorders (affective)	123 million

**Source: World Health Report, 1997**

**Major causes of death**

In 1996, WHO estimated that 52 million deaths occurred worldwide. The majority of these deaths (40 million - 77%) occurred in the developing world. Over 17 million (32%) of these 52 million deaths were due to infections and parasitic diseases. These include acute lower respiratory infection, tuberculosis, diarrhoea and malaria. Over 15 million (28%) were due to circulatory system diseases, which include ischaemic heart diseases and cerebrovascular diseases. Cancers accounted for 6,3 million deaths (12%).

A finer breakdown showing the 10 leading causes of death worldwide is presented below:

**Table 2: Leading Causes of Mortality, 1996**

Leading causes of mortality 1996 (estimates) <sup>22</sup>	Rank	Number ('000)
Ischaemic heart disease	1	7,200
Cerebrovascular disease	2	4,600
Acute lower respiratory infection	3	3,905
Tuberculosis	4	3,000
COPD	5	2,888



Leading causes of mortality 1996 (estimates) <sup>22</sup>	Rank	Number ('000)
Diarrhoea (including dysentery)	6	2,473
Malaria	7	1,500-2,700
HIV/AIDS	8	1,500
Hepatitis B	9	1,156
Prematurity	10	1,150

Infectious diseases play a major role in the 10 leading causes of deaths. Most of these diseases are preventable.

The successes and challenges in health status do not occur in a vacuum, but in a particular health settings. The successes gained were facilitated by supportive environments such as policies, research and programmes that promoted disease control, provision of clean water, better housing, aggressive family planning programs, education and the end of the cold war era.

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The challenges that we face will require those health environments that are conducive to health promotion. These include policies, research and programmes that aim to address health problems occurring during the epidemiological transition. Many of these health problems affect both the developed and developing countries, they affect rich and poor areas within our countries, they affect the rural and the urban areas.

Globally we are bound to develop health sector reform policies that will sustain the gains we have made and also make it possible to address the challenges we face now and in the future.

## **THE CHALLENGE OF HEALTH SECTOR REFORM**

The recognition that many of the determinants of health are to be found outside the health sector has led to widespread reform in the health sector globally. Health sector reform has to occur in tandem with social sector reform, i.e., we have to move from a welfare dependence creation state to one of social development and empowerment. This means we should develop reconstruction and development policies and programmes that are people-centred, programmes that ensure jobs are created and that people have basic needs such as healthy housing, access to basic health care and universal access to basic education.

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In the health sector a major challenge to governments is developing policies and programmes that aim to integrate health systems, adequately manage health services, equitably allocate health resources, reform pharmaceutical services and contain the escalating cost of health care.

### **Creation of integrated health systems based on PHC**

A growing movement is underway to create single national health systems, which integrate the public and the private health care organisation in order to promote national health goals. These systems will ensure a suitable environment exists for development of health programmes to address common health problems.

### **Decentralisation of management of health services**

A decentralised health care system is the cornerstone for efficient health service delivery. The aim is to create a national health system which focuses on health districts as the major basis of implementation of primary health care. The district health system is frequently used as a vehicle to overcome fragmentation in health service delivery, ensure equity of access to services, provision of efficient, effective and quality comprehensive health services. Such a system allows for local accountability as communities participate in planning the services and ensures the involvement of other sectors. This decentralised system for the provision of health care needs to be studied and evaluated for effectiveness and efficiency.

### **Improved Resource allocation**

We need to improve resource allocation so we can target resources towards proven cost-effective interventions. For example, often TB treatment is hospital-based instead of utilising alternative strategies which are cheaper and more efficient. One such strategy is the DOTS, utilising a community based method of encouraging people to complete their medication and providing the support needed by the patient. In spite of evidence to prove the efficacy of the DOTS strategy, only about 10% of all TB patients were treated with DOTS in 1996! (*WHO, 1997*).<sup>23</sup>

Health resource allocation is only not targeted but is allocated inequitably. Those who need health care most, such as rural and peri-urban areas, often have poor or no access to health care. Middle to upper class neighbourhood dwellers, have access to more general practitioners and specialist care facilities in their neighbourhood than they can use. There is a need to shift resources from over-served areas to under-served areas.



### **Pharmaceutical reform**

There is a need to reform pharmaceutical policies and programmes to ensure safe, cost-effective and affordable medicines reach the entire population regardless of cost. These policies include introduction of essential drugs programme, rational drug use, single exit price at manufacturer level, handling fees to replace price mark-ups, and generic substitution, parallel importation and regional international tendering of medicines. The priority should be the patient and not those who make huge profits at the expense of patients!

### **Cost-containment strategies**

The rising cost of health care is a major concern. The use of expensive technology, increased cost of medicines, unaffordable health insurance and inappropriate diagnosis and treatment all contribute to escalation in cost of health care and hence fewer people have access to quality health care. We need to look at ways of containing costs. A method for this could be the sharing of resources between countries.

### **Political support**

Health cannot be improved without political support and a commitment towards development. Health promoters need to be in the forefront of advocating for more political support for health promotion.

## **CONCLUSION**

Having looked at the successes we have made and the challenges still facing us, and having examined the health environment necessary for sustaining the gains made and for conquering the challenges ahead, the question is where to now?

We need to locate health promotion within the paradigm of a comprehensive health care. We need not argue about health promotion as competing with curative care, but rather how does it complement curative, rehabilitative and disease prevention services. This means we should integrate health promotion within the paradigm of comprehensive health services within the primary health care model.

Health promoters need to be advocates for world peace to rid of the major determinant of poor health, i.e. poverty. Health promoters need to support reform of the health sector to create a supportive environment for people to be healthy. Health promoters need to expand the rhetoric of intersectoral collaboration and even define better in what activities communities should be involved. Lets all get ready for the next millenium and enter it armed with appropriate policies, programmes and plan of action.

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## BIBLIOGRAPHY

1. World Health Organisation. (1996). The World Health Report 1996: Fighting disease, Fostering development. WHO: Geneva
2. The World Bank. (1993). World Development Report 1993: Investing in health. Oxford University Press: USA
3. World Health Organisation. (1996).
4. World Health Organisation. (1996).
5. World Health Organisation. (1996).
6. World Health Organisation. (1996).
7. The World Bank. (1993).
8. World Health Organisation. (1997).
9. The World Bank. (1993).
10. World Health Organisation. (1997).
11. World Health Organisation. (1997).
12. World Health Organisation & UNICEF. (1995). A Picture of Health: A review and annotated bibliography of the health of young people in developing countries.



13. World Health Organisation. (1997).
14. World Health Organisation. (1997).
15. The World Bank. (1993).
16. World Health Organisation. (1997).
17. World Health Organisation. (1997).
18. World Health Organisation. (1997).
19. World Health Organisation. (1997).
20. World Health Organisation. (1997).
21. World Health Organisation. (1997).
22. WHO Report 1997
23. WHO Report on the Tuberculosis Epidemic 1997



**New Players for a New Era: Leading Health Promotion into 21st Century  
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## **SPEECHES AND PRESENTATIONS**

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### **FAMILY REPRODUCTIVE HEALTH DEVELOPMENT IN INDONESIA: THE FAMILY APPROACH TO FAMILY HEALTH PROMOTION**

**Dr H. Suyono**







**FAMILY REPRODUCTIVE HEALTH DEVELOPMENT  
IN INDONESIA:**

**The Family Approach to Family Health  
Promotion**

**KEYNOTE ADDRESS**

**BY**

**PROF. DR. HARYONO SUYONO  
STATE MINISTER FOR POPULATION /  
CHAIRMAN  
NATIONAL FAMILY PLANNING  
COORDINATING BOARD,  
REPUBLIC OF INDONESIA**

**TO**

**THE INTERNATIONAL CONFERENCE  
ON HEALTH PROMOTION**

**Jakarta, July 22, 1997**

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**THE STATE MINISTRY FOR POPULATION /  
NATIONAL FAMILY PLANNING COORDINATING BOARD  
JAKARTA, 1997**







**KEYNOTE ADDRESS  
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REPUBLIC OF INDONESIA**

**Distinguished Ladies and Gentlemen,**

It is indeed a great pleasure for me to address this international conference on health promotion and to share with you some of our experiences in implementing our population and family planning programs in Indonesia. In this respect I shall give emphasis on the issue of enhancing the quality of the family life as an integral part of the family welfare development through the Family Approach.

**Overview of the early years of the Family Planning in Indonesia.**

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Indonesia is the world's fourth most populous nation, after China, India and United States of America. It is not a feat, nor something to be proud of, but as one will see, the sheer number of population is not only detrimental, but at the same time it has its contributing elements for national development. Indonesia is one of the largest archipelago countries in the world, with about 17,000 islands 9,000 of which are inhabited. The estimated total population in early 1997 is 200 million, with growth rate of about 1.6 percent.

Since the late 1960s we were aware of the negative consequences of rapid population growth on attaining our goals especially those with regards to the welfare of our people. It is therefore that President Soeharto considers population issues as one of the highest national priorities. In 1970 the National Family Planning Coordinating Board was established to ensure that adequate attention to the development of "the family" as the smallest important institution in the community are provided with high attention. In our project we made sure that contraceptive services are provided to every married couples who wishes to plan their families and to ensure that activities towards the materialization of family welfare are implemented properly.

Looking at the Indonesian population growth, two main components are apparent:

- The population is increasing because many couples have more children than they actually wanted; and
- The low welfare status of many couples causes them to want more children to replace the high death rate of children.

Responding to these two components Indonesia adheres to developing complementary and integrative national policies, i.e. policies with regards to the total spectrum of population and development, policies on family planning, and specific policies for prosperous family development which regard to materialize the material and spiritual prosperity of families as part of the national total development programs within the soonest possible time in accordance to prevailing religious and socio-cultural beliefs.

Our family planning program is now in its twenty-fifth year. Indonesia's family planning program is acclaimed as highly successful in the region and probably in the world. This success is the fruit of hard work, with the inherent trials and errors, and the invaluable lessons learned. It has been the result of integrated programs of 25 years of normative change from the values which say "... **big family with many children brings benefits for tomorrow ...**" to "... **small family is a happy and prosperous family ...**". This social phenomena of social change is in itself a revolution which progressed without significant opposition from community, and during the same period contraceptive services also evolved from the clinic-based to the community-oriented.

With this societal change which transformed cultural and traditional values, came the community's acceptance to contraceptive services. That, in turn, brought about changes in the demographic pattern of the nation. With those, also came the social phenomenon that the majority of married couples in the reproductive ages have, or are practicing family planning.

Then, as Indonesia's fertility decline approaches the replacement levels, new challenges enter the scenario. These new challenges can be considered as the '**beyond family planning**' activities. These activities are indeed very complex, and include the broad range of reproductive health from the quality of services, to sustainability of services. All of these are carried out through the community institutions of family in family planning.

A question, which readily comes to mind, is then, what is the linkage between Reproductive Health and Family Planning. When one observes closely the Program of Action emanating from the International Conference on Population and Development (ICPD) in September 1994 in Cairo, the conference accepted the definition of **Reproductive Health** as the state of complete physical, mental and social well-being of



individuals, and not merely the absence of disease or infirmity. It means that legally married couples as the smallest unit in the community are able to enjoy satisfying and safe sexual life, and that they have the capability to reproduce, and have the freedom to decide if, when, and how often to do so. Certainly, in order to exercise those freedoms, reproductive health requires access to family planning and related health services. That, is the portrayal of the position of family planning in the larger spectrum of Reproductive Health.

## Quality of Care

Refocusing one's attention of the quality of care, as aforementioned, quality is most essential as an element of satisfying the basic need of family planning clients. In that regards the government of Indonesia is very much concerned, and committed to continuously and consistently improve the quality of family planning services. From the Indonesian perspective, quality of care is not only based on the quality of contraceptive services, rather quality is divided into four parts, i.e.

- the management aspect,
- the provider's aspect,
- the client's and the family's aspect, and
- the community's aspect.

Turning ourselves to another issue, one could readily observe that with most national governments family planning program began to enjoy political and economic support because they address what most saw as the major cause of deprivation -- rapid population growth. As a result, the resources the program commands are greater than what would have been available if their only goal were in health. There are, of course, from the management aspect, co-ordination and integration of program with many institutions, both public and private, and also from the central level down to the operational levels. This remains one of the potential strengths of family planning program. It is only 'potential' if these are not recognized and exploited in full.

Quality of management, on the other hand, is one aspect that assures and guarantees the quality of services in the field. If a family planning program were to be denied this, then dismal quality of the total program is the resultant.

In this very regard, improvement of the quality of the program and of the quality of service in the Indonesian context is continuously looking for, and implementing new health and medical techniques and the appropriate high-technology instruments.

To improve the quality of services from providers' aspect, every two to three years, Indonesian health and medical professionals update, revise and edit standards for contraceptive services with up-to-date technology and medical techniques. This is done with utmost care and in accordance to the unique Indonesian situation. All of these are



published in the "National Resource Document" of the Indonesian Obstetrics-Gynecologist Association. This, in fact, is the manual for standardized services. Routine training for new physicians and para-medical personnel and refresher training also assures quality of services.

### **Empowerment of the Family.**

It is important to note that Indonesia has gone some steps further. We are now at a stage, which requires a shift in the implementation approach, and in the restructuring of the thoughts about promoting and providing family planning services. Our primary focus now is no longer on conventional family planning, with or without the beyond family planning additions for married couples. At present our concern is on the **Indonesian family as an institution**. While we continue to provide opportunities for people to limit their family size if they so desire, while we still encourage safe motherhood, raise their family income, etc., **we also empower them particularly the female members as agents of development for their own family prosperity**. The family in this new construct is the planner, the promoter, the participant, and decision-maker in development movement. This is the basic concern of our society today. It is not only logical and appropriate but has become the major focus for a successful population and development program, including family planning.

Naturally, as the Indonesian people have matured in their way of living and way of planning for their future, BKKBN has also had to rethink to maturity. It is now evident that Indonesian families are ready preparing to manage and implement their own family planning needs by themselves so the responsibility for the management of the family planning program are now shifting from 'management by BKKBN/government' to **management by the families and the communities**. So as families first and foremost they are also participants of the family planning program, which is now, become a society movement.

The fact was that our information from the fields, from studies, surveys and operational experiences have shown us that after 25 year of family planning, many family planning acceptors have internalized the need for planning a family. There were indications all over the country that people and families are no longer see family planning as only a program promoted by the government, but rather as their real need, a need that they are even willing to pay for. As socio-economic levels rise, so does the need to get deeper and more comprehensive information. They want information to enjoy personalized and customized services, to be more "fashionable", to "show-off" social-status, and part of that status is pay private doctor or midwife for family planning. Potential acceptor segmentation and targeting of messages through mass media are approaches that go beyond the basic commodities and general IEC messages. These are what the new era demands and every successful family planning programs must be ready to evolve to meet these demands.

## **From Programs to Movement.**

This was a major shift in the attitude and behavior of people/ families in Indonesia, and these are reflected now in our entire program, which now have been labeled as a **MOVEMENT**. This has required a fundamental change in structure and operational of the Indonesia Family Planning Program, as we enter a new era. We are now at the height of these changes and has gone through many stages of development. One of the transition stages is to a full family planning, health and development through family approach. Family planning and health especially maternal and child health becomes an integral part of the total family development activities. Our primary focus is in improving the total development inputs to the Indonesian family as an institution. Thus we design programs so that every family/people can see and realize the difference family planning makes in their quality of their daily family life. In this instant we perceive family simply as an institution that receives all of the benefits from society, but also as the engine, the advocate who makes their own decision for their own development for the future.

### **Promotion of Healthy Family life (1)**

Having related the background of the present day's family empowerment and family approach to national development, let us apply those principles to the promotion of health in the Indonesian context. One is reminded that according to the latest family registration, Indonesia has a total of 42 million families, indeed a formidable force for social change and development if, and only if, this asset is capitalized appropriately.

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We all recognize that health is the goal of every individual, especially in the pursuit of **Health for All by the year 2000**. Health is a pleasure, and a goal for continuous fulfillment. Once this pleasure is taken away, the individual and his/her surroundings are deprived of their desired happiness. Within the context of the family, the whole family becomes happy when each member is healthy and able to fulfill their respective tasks. The togetherness in family life and the cohesiveness of community fabric hinges so much on this.

One other element worth highlighting is that healthy individuals, and hence healthy families, interact more openly with health providers compared to those families who are having problems. This open interaction is an element of sustained and farther health improvement. It is in this context that individual and families may be able to recognize their own health limitations, and know when they are to seek health or medical services.



## Promotion of Healthy Family Life (2)

The key to the promotion of community health is the family. What matters more is that families should be led, empowered and guided to care for their own health. One of the basic prerequisites for this is to educate families to internalize appropriate health habits. Very basic tenets such as ways to eat right - which can be fulfilled even at a low cost, appropriate mouth and dental hygiene, and regularity in doing sports. Also in these habits should one lead to the often talked about its effects of Tobacco consumption, of alcohol and other dangerous substances. With all of this, health should be a pleasure to maintain and sustain, and should not be looked upon as a sacrifice.

One should also bear in mind that the internalization of healthy living should begin very early in life. Even in the infant years babies should be taught to avoid certain practices, such as excessive thumb-sucking, and other things. On the other hand mothers and parents would also need to be taught on appropriate nutritional requirements of their infants.

In later years the children and the whole family would need continuous and sustained encouragement such that they know that their health practices are correct. In this rubrics awards can be given to healthy families, not only for their acquired health status, but more to applause their health habits. In regard one can introduce the concept of the Promotion of Healthy Living.

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## Promotion of Healthy Family life (3)

Perhaps award can also be given to families in the form of basic hygiene implements, such as soap, toothpaste, and also sport shoes together with training suites.

The latest is another aspect of the promotion of healthy family life, i.e. through the **Promotion Sport**. Sports should be looked upon as a pleasure, a habit and a means to healthy life. It should be participated by the whole family rather than just individuals, even though the sport branch is individual, such as tennis or swimming. More importantly sports should be considered as a recreational activity which are to be takes on a regular routine.

In this regard the socialization of sports is not only a series of activities, but rather a massive movement carried out on a sustained manner. Hence the analogy into a Health Promotion Movement.



## The Scope of Family Health Promotion

From all of the above mentioned, it would be apparent that the analogy of reproductive welfare movement can be applied to another principle whereby the promotion of family healthy life should be categorically revisioned for, and by all. It should not be applied selectively, and above all should not be exclusive. All segments of the populace should be exposed to this.

In this regard one can draw an example from a well-working Puskesmas (Health Center). To judge its performance one should not only count the number of clients coming to the Health Centers, as they may be the same persons coming for further treatment. Rather this health center should be judge by the coverage home visit or total number of families served. In this context I would like to submit a principle of **Population-Centered Coverage**, rather than center based coverage.

### Concluding Notes

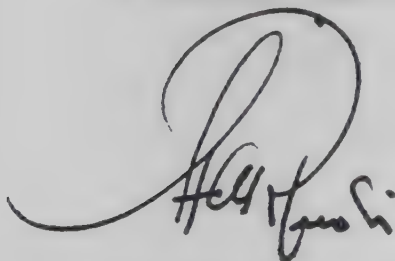
Indeed health is a vehicle for a happy and prosperous family life, and is therefore to be given the deserved emphasis. Yet in many instances health is exclusively associated with the medical aspect, and little is devoted to the social elements of healthy living.

Let us anticipate the future with vigor and enhanced healthy conditions to pursue family prosperity and our children's aspirations.

May the Almighty shed His blessings and guidance to us all.

Thank you.

Wassalamu'alaikum Wr. Wb.



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**Prof. DR. Haryono Suyono**  
State Minister for Population /  
Chairman - National Family Planning Coordinating Board  
Republic of Indonesia



**New Players for a New Era: Leading Health Promotion into 21st Century  
Fourth International Conference on Health Promotion  
Jakarta, Indonesia, 21-25 July 1997**

## **SPEECHES AND PRESENTATIONS**

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### **WESTERN PACIFIC SCENARIOS: NEW HORIZONS IN HEALTH**

**Dr S.T. Han**





PANEL PRESENTATION  
AT THE 4TH INTERNATIONAL  
CONFERENCE ON HEALTH PROMOTION,  
Jakarta, Indonesia,  
21-25 July 1997

**WESTERN PACIFIC SCENARIOS:  
*NEW HORIZONS IN HEALTH***

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DR S.T. HAN,  
REGIONAL DIRECTOR,  
WHO REGIONAL OFFICE  
FOR THE WESTERN PACIFIC

MADAM CHAIRPERSON,  
LADIES AND GENTLEMEN,

It is projected that the population of the Western Pacific Region will grow from 1.6 billion in 1995 to 2 billion in 2020, an increase of 400 million or 25%. By 2020 there will be six cities in the Region with populations greater than 20 million and more than 20 cities with populations greater than 2 million. This projection is based on an assumption of continued reduction in infant mortality, and a reduction in the rate of population growth as a result of population programmes. The regional picture is heavily influenced by China, which makes up 76% of the total population in the Region. There will be significant differences in the demographic picture emerging by 2020. For example, there will be a dramatic reduction in the under-15 age group and a rise in the over-65 age group from 6.5% of the total in 1995 to 9.7% in 2020.

While there will be significant health benefits associated with the socioeconomic development which is projected for the Region by 2020, population growth, rapid urbanization, unhealthy behaviours and damaged environments will lead to significant increases in some diseases and conditions. For example, in 1995, the 25-65 age group was affected by a combination of communicable diseases, nutritional and maternal conditions, noncommunicable diseases and injuries. By 2020, this age group will be predominantly affected by noncommunicable diseases (such as cardiovascular diseases, diabetes and hypertension) and injuries (such as traffic accidents and industrial injuries). This is the general picture;



however, we should not forget that, in some countries in the Western Pacific Region, communicable diseases will continue to be a burden.

In response to the rapidly changing demographic and epidemiological conditions in the Region and the associated need for new, more effective approaches to solving complex health problems, WHO in the Western Pacific Region has developed a regional policy framework called *New horizons in health*. This policy document reflects a shift from a disease-centred approach to a people-centred approach, and includes a commitment to equity and gender sensitivity. It emphasizes that people have the potential to make long-term differences to their own health, as well to the health of those they influence. It is a framework for exploring the best ways to encourage and empower people to help themselves and to develop healthy lifestyles.

Although people can look after many aspects of their own health, there are external factors, such as the environment, which greatly influence health and quality of life. For example, a major question for the future is how to ensure that health and the environment are not damaged by the economic progress for which people have worked so hard. This is where the public sector can support the individual. These twin concepts, individual responsibility and public sector support for healthy living, are central to *New horizons in health*.

Operationalization of the concepts of *New horizons in health* is developed around three themes and related indicators: preparation for life in the early stages; protection of life throughout adulthood; and quality of life in later years.

Preparation for life should ensure that children and young people not only survive the first years of life, but are suitably prepared to realize their health potential throughout their lives. Programmes aimed at this early stage of life include the promotion of responsible parenthood, immunization of children against target

diseases, the provision of safe water and adequate sanitation, and development of healthy lifestyles in young people.

In the Western Pacific Region, the development of health-promoting schools has been a very successful approach under preparation for life. Since 1995, WHO has supported the development of health-promoting schools in 17 countries and areas. Regional guidelines on the development of health-promoting schools have been translated and adapted in many Member States. This is a long-term strategy and health-promoting schools will not have their most visible impact until the next century. Nevertheless, we believe that our investment in this stage of a person's life will pay dividends in later years.

The next stage, protection of life, aims to ensure that individuals are supported in fully developing and maintaining healthy lifestyles and that they are protected from illness caused by potentially hazardous and degraded environments. The overall aim is to prolong productive, healthy and disability-free lives in the most cost-effective and equitable way possible.

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In our Region, our concept of Healthy Cities and Healthy Islands, using relevant, timely entry points such as food safety in the marketplace in Haiphong, Viet Nam, and malaria in the Solomon Islands, in selected countries, has helped to encourage positive health. At present, WHO collaborates with Cambodia, China, the Lao People's Democratic Republic, Malaysia, Mongolia, and Viet Nam in 14 Healthy Cities projects. Existing Healthy Cities projects are being extended to other cities using the experiences of the core group of cities. Healthy Islands projects are particularly relevant to the many small island states of the Pacific. In 1995, the concepts reflected in the Healthy Islands approach and in *New horizons in health* were endorsed by a conference of Ministers of Health of the Pacific Islands in the historic Yanuca Island Declaration. Several projects have been undertaken following this Yanuca Island Declaration which reflect a wide variety



of entry points, as well as differing local situations and collaborative arrangements.

The aim of the third theme of *New horizons in health*, quality of life in later years, is to enable all individuals to maintain the physical, social and mental capabilities required to lead fully creative, productive and meaningful lives in later years. WHO is supporting programmes for the elderly in many countries in the Western Pacific Region. There is an emerging shift in the health services to provide quality care for the expanding elderly age groups and the growing number of people who live with a chronic illness. Experience shows that patients with chronic pain, for example, are often able to realize their potential for a better quality of life provided they receive adequate professional and community support. Provision of high-quality care for people in their later years is particularly important in the Region where the percentage of elderly people is increasing rapidly. Because it is important that we should quantify our successes and shortcomings as far as possible, health indicators, as well as other social and economic indicators, have been identified for each of the three themes. We have intensively worked with Member States to reach an agreement on a minimum set of indicators. They include some of the health-for-all indicators, which provide a way of monitoring how overall health-for-all policies are implemented at country level. New indicators need to be continuously identified, as we extend our programmes in response to new health challenges.

The concepts and approaches described in *New horizons in health* have been given high-level political commitment from a large number of countries. It was also recognized as the regional response to revising WHO's Global Policy for Health for All. Practical implementation has already started and is building momentum. Several countries and areas have used *New horizons in health* to develop health policies and plans. Papua New Guinea, for example, has



developed a National Health Plan for 1996-2000 which made a shift in programme and budget focus from curative care to health promotion and prevention programmes. In China, *New horizons in health* has been used widely in developing national and provincial health plans. These include the Ninth Five-year Plan and the long-term health plans until the year 2010, which was presented at the National Health Conference in 1996.

These are just a few of the ways in which the concepts contained in *New horizons in health* are being turned into policies which will make a difference to people's lives. If together we succeed in fostering and managing all these developments, we have a chance of securing a future where we live longer, healthier, and better quality lives. People need not die prematurely; the living can lead productive lives, age gracefully, and die with dignity.







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### **TOBACCO CONTROL TRENDS IN DEVELOPING COUNTRIES - EGYPT**

**Dr S. Omar**



# TOBACCO CONTROL TRENDS IN DEVELOPING COUNTRIES - EGYPT

By

SHERIF OMAR, M.Ch., FACS

Professor of Surgical Oncology, Cairo University

Member of the Egyptian Parliament

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Ten years ago, the WHO forewarned that smoking diseases will appear in developing countries before communicable diseases and malnutrition have been controlled; thus the gap between rich and poor countries will expand more and more. The Director General of Pan American Health Organization said that tobacco is rapidly becoming the 21st century Brown Plague of Latin America, and unless actions are started from now, by the year 2000 more than one million Latin Americans will die each year prematurely and painfully from tobacco-caused diseases. In 14 less developed countries (LDCs), life expectancy remained below 50 years in 1986, while in 6 others it was 45 years or below. In these countries, chronic diseases like lung cancer and heart disease are generally uncommon because of the relatively few people who survive to that age when such diseases become manifest. In most developing countries, the availability of health data and patterns of tobacco use is poor and unreliable. Smoking becomes risky particularly in poor countries where populations are anaemic and have poor oxygen reserve capacity, because it reduces the blood's oxygen-carrying capacity. In the very poor, tobacco is often used as an appetite suppressant, being cheap and an accessible means of warding off hunger pangs when food is unavailable or too costly. It was noted that in lives characterized by terrible poverty



and hopelessness, the mean consolation obtained from the pleasure of smoking or chewing modest amounts of tobacco is very understandable and that the precept of pursuing policies that would deny such a palliative use of tobacco might be questioned. Few governments in the Third World are keen on making decisions that lead to effect changes in the long term, being more interested in immediate health and economic issues. Tobacco is not just a health issue, it is also an economic variable essentially concerned with social value and waste.

The area of land under tobacco cultivation throughout the world was 4109 hectares in 1985; 73% of which is in developing countries. Tobacco occupies 3 hectares in every thousand of the world's arable land. The total profits on tobacco per hectare are normally 5 times that of maize, and 3-4 times that of cotton and peanuts. Some important questions are thus raised: 'how can alternative crops be encouraged?' or 'why is the industry of tobacco so favoured?' Also, 'what would be the situation if funds currently used for tobacco cultivation were employed to other crops?' The answers exist in the influence of the transnational tobacco companies and their massive financial support which they bring on key individuals.

For mass reach of health education messages, campaigns against smoking require substantial financial commitment as well as educational and communications arrangements capable of spreading their health messages to hundreds of millions of people living in populous countries like China, Indonesia and Brazil. Still there are immense barriers to the widespread dissemination of health education against tobacco in LDCs; the high rate of illiteracy and the difficult reach to media (TV and newspapers) contribute markedly in that respect. The role of the medical profession has been important to the progress of many aspects of smoking control in developed countries. Doctors are often in powerful positions to influence both patients and government policy;

and such potential has been acknowledged by the WHO and non-governmental organizations like the UICC. In developing countries, this role is not present and medical professionals are among the groups of high smoking prevalence.

In developed countries, the tobacco burden is estimated at 16% of all annual incident cancer cases, while in developing countries, it is 10%. Out of a total of 676000 cases of lung cancer in men, 85% are attributable to tobacco smoking. In regions where males have smoked for several decades, 30-40% of all men's cancers are attributable to tobacco. Unless tobacco control efforts in developing countries are strengthened, the enormous increase in cigarette consumption will produce a comparable rise in cancer cases in these countries within the next 20-30 years.

Population structure in the Middle East, which is to a great extent similar to other developing countries shows that 50% of the population is below the age of 20 and they are the target of the tobacco propaganda. They are potentially motivated to start and continue as regular smokers. The history of tobacco in the Middle East started since about 415 years. Tobacco was introduced by means of two different ways; the first was through the route of Morocco; and the second was by the way of Turkey, by an English man who brought the stuff from Europe, but afterwards, it was cultivated and widely used.

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Since then the smoking behaviour started and became quite a social habit among the population and is still gaining grounds in the Middle East, where around 40% of males above the age of 12 are regular daily smokers. Smoking among females is still low. Cigarette smoking is also used as a sort of greeting in their entertainment; but it is not the only method in use in the Middle East, the Hubble Bubble type of smoking is also a common method which is considered a partner in



the smokers' leisure time. This type, which in certain countries is used by 25% of the daily smokers, is considered to be less harmful to health, from the cancer point of view.

Islamic Religion Leaders in the Middle East started to take part in the fight against smoking and they found in the Holy Quran certain verses which incite good Moslems to quit smoking, giving explanation why. Also, legislation against smoking is not seriously implemented in most countries of the region, and in some countries the tobacco business violates the law, especially as regards sales promotion and advertisement. An early WHO report drew attention to the threat to the Third World from multinational tobacco companies seeking new markets. A recent report concluded that the threat had become a reality.

98      The new concept that smoking induces nicotine addiction, thus considered nicotine an addictive drug. This fact is gaining support from international scientific agencies to throw some light about addiction, which can generally be defined as 'the repeated use of a psychoactive drug which is difficult to stop.' Many studies, including some hidden by the tobacco industry, show that nicotine does produce chemical reactions in the body similar to those produced by heroin or cocaine. The relapse rates of addicts trying to quit using nicotine, alcohol, cocaine and heroin are about the same, and many report that it is harder to quit smoking than using various illegal drugs. A new study by the Center on Addiction and Substance abuse at Columbia University confirms that nicotine is a "Gateway Drug" which often leads to the use of illicit substances. About 65% of cocaine users started by smoking cigarettes. Adults who started to smoke before the age of 15 are three times as likely to be regular hard drug users and more than twice as likely to be regular cocaine users than those who started smoking at 18 or older. Children who smoke daily are 13 times more likely to use heroin than children who smoke less often. It was estimated that 3000 children become



addicted to smoking every single day.

Anti smoking policy has to be identified as a part of every health strategy in LDCs. Health education; information and smoking cessation programs must work hand in hand with legal regulations of tobacco production, sales and advertisement which must be banned completely.

# BASIC COMMUNICATION PARAMETERS IN ARAB COUNTRIES (1990)

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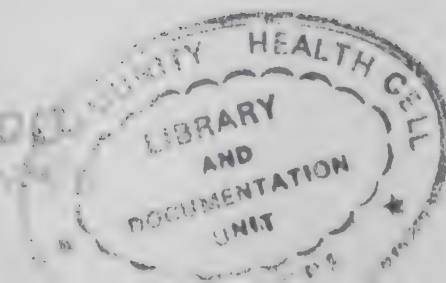
COUNTRY	RADIO SETS FOR 100 PERSON	T.V. SETS FOR 100 PERSON	NO.OF TIMES ATTENDING CINEMA YEARLY FOR 100 PERSON	DAILY NEWS- PAPERS (NO. OF ISSUES FOR 100 PERSON)
	1990	1990	1988-1991	1990
Kuwait	33	27.1	0.6	21.0
Qatar	44	44.5	0.7	18.7
Bahrain	55	41.4	-	5.7
United Arab Emirates	32	11.0	-	15.7
Saudi Arabia	30	26.9	-	4.0
Syria	26	6.0	0.6	2.3
Libya	22	9.9	-	1.5
Tunisia	20	8.1	-	3.7
Oman	64	75.5	-	4.0
Jordan	25	8.1	0.3	5.6
Iraq	22	7.2	-	3.6
Lebanon	83	32.5	-	11.7
Algeria	23	7.4	0.9	5.1
Egypt	32	10.9	0.5	5.7
Morocco	21	7.4	1.2	1.3
Moon Islands	13	0.0	-	-
Yemen	3	2.9	2.5	1.1
Sudan	25	7.1	0.6	2.4
Moritania	14	2.3	-	0.1
Djibouti	8	5.2	-	2.0
Somalia	4	1.2	-	-
All Developing Countries	18	5.5	3.0	4.4
Industrial Countries	113	54	2.3	30

ILLITERACY RATE AMONG ARAB COUNTRIES  
( 1992 )

Country	General (Males/Females)	Females
Jordan	19.9	29.7
Bahrain	22.6	30.7
Tunisia	34.7	43.7
Algeria	42.6	54.5
Saudi Arabia	37.6	51.9
Sudan	72.9	88.3
Syria	35.5	49.2
Somalia	75.9	86.0
Iraq	40.3	50.7
Qatar	24.3	27.5
Kuwait	27.0	33.3
Lebanon	19.9	26.9
Libya	36.2	49.6
Egypt	51.6	66.6
Morocco	50.5	62.0
Yemen	61.5	73.7

Source: World Bank, April 1992

HPE-100  
06817





TAR, NICOTINE AND CARBON MONOXIDE CONTENTS IN LOCAL BRANDS - EGYPT

Brand	1988			1993		
	Tar mgm	Nicotine mgm	Carbon Monoxide mgm	Tar mgm	Nicotine mgm	Carbon Monoxide mgm
Cleopatra King Size	17.67	1.25	11.00	17.13	1.02	9.8
Cleopatra Super	16.82	1.13	12.29	16.97	0.94	10.5
Belmont	14.70	0.99	13.10	15.22	1.01	10.4
Cleopatra Lux	13.61	0.92	11.90	15.50	1.02	11.5
Cleopatra Lights	12.76	0.84	11.50	11.67	0.74	11.6
Lite	-	-	-	10.63	0.65	10.5
Port Said	17.75	1.20	12.30	17.72	1.32	13.1

PERCENTAGE OF FAMILY BUDGET EXPENDITURE IN URBAN AND RURAL AREAS - EGYPT (1996)

IN COMPARISON TO THE PREVIOUS STUDY

Main Expenditures	U R B A N			R U R A L		
	1993	1996	Change (%)	1993	1996	Change (%)
1) Food and Beverage	49.96	46.79	- 3.17	59.35	56.37	- 2.98
2) Tobacco	4.27	3.43	- 0.84	4.67	4.10	- 0.57
3) Clothing and Footwear	8.41	9.71	1.3	7.55	8.52	0.97
4) Housing	8.82	9.29	0.47	10.44	11.00	- 0.24
5) Furniture, equipment and house services	4.86	5.01	0.15	4.26	4.02	- 0.24
6) Health care services	4.42	4.07	- 0.35	3.43	3.53	0.10
7) Transportation	6.36	6.17	- 0.19	2.79	3.03	0.24
8) Education	2.90	4.61	1.71	1.67	3.28	1.61
9) Culture sports and recreation	3.17	4.54	1.37	1.76	2.49	0.73
10) Restaurant, cafe and hotels	2.35	1.61	- 0.74	0.97	0.72	- 0.25
11) Others	4.47	4.76	0.29	3.10	2.94	- 0.16

No. of Families Studied	8354	6622	--	5881	8183	--
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Central Agency for Mobilization and Statistics

MEAN AGE FOR STARTING THE SMOKING HABIT  
IN RELATION TO RESIDENCE  
(FAKKOUS REGION\* - EGYPT)  
1 9 9 4

	MEAN	S.D.	T.VALUE
Urban	24.04	5.99	2.402
Rural	21.60	4.9	

P < 0.05

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\* Population Size 500.000  
Sample Size 1 : 1000



SMOKING PREVALENCE IN FAKKOUS REGION\*

EGYPT - (1994)

33.46%

AMONG FEMALES:

Rural	5.0%
Urban	4.6%
Both	4.8%

Goza Smokers	33.0%
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AMONG MALES:

Rural	49.3%
Urban	35.3%
Both	43.6%

Goza Smokers	25.6%
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\* Population Size 500.000

Sample Size 1 : 1000

PERCENTAGE OF SMOKING IN RELATION TO AGE  
(FAKKOUS REGION - 1994)

< 20 Y	2.4 %
20 -	22.23%
30 -	42.85%
40 -	37.36%
50 -	36.84%
60 +	58.33%
TOTAL	33.47%

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\* Population Size 500.000

Sample Size 1 : 1000

DISTRIBUTION OF THE STUDIED SUBJECTS  
ACCORDING TO SMOKING TYPE

TYPE	PERCENT
Cigarettes	72.89
Goza	24.7
Cigar	0.6
Mixed	1.81

\* Population Size 500.000

Sample Size 1 : 1000

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PERCENTAGE OF SMOKED TYPE IN RELATION TO SMOKERS  
(FAKKOUS REGION - 1994)

	Cigarette	Cigar	Goza	Mixed	Total
Urban	87.94	1.72	5.17	5.17	100
Rural	64.81	0	35.19	0	100
Total	72.9	0.6	24.7	1.8	100



## BALANCE SHEET - 1987 (IN MILLION L.E.)

## EGYPT

CONTRIBUTION TO THE ECONOMY		COST TO THE ECONOMY	
Wages	51.9	Imports of unmanufactured tobacco and other requirements	276.5
Retailer's gross profit	94.4	Subsidies on cigarette exports	0.6
Gross value added (excluding wages)	175.8	Expenditure on health care	171.6
Exports of cigarettes	16.5	Loss of production due to early death	71.7
Taxes raised on tobacco products	817.0	Expenditure on sick-leave	9.6
		Expenditure on social affairs	24.4
		Expenditure on tobacco products	1525.5
		Loss of income due to early death	27.3
Total	1155.6	Total	2107.2

## World tobacco consumption per capita (adults 15 years and over)

	Cigarettes per adult (over 15 years of age)			Annual % change
	1970-1972	1980-1982	1990-1992	1980-1982 to 1990-1992
More developed countries	2860	2980	2590	-1.4
Established market economies	2910	3000	2570	-1.5
Formerly socialist economies of Europe	2450	2830	2770	-0.2
Less developed countries	860	1220	1410	1.4
China	730	1290	1900	3.9
India	1010	1310	1370	0.4
Other Asia and islands	780	1130	1190	0.5
Middle Eastern Crescent	950	1240	1200	-0.3
Sub-Saharan Africa	410	490	500	0.2
Latin America and the Caribbean	1430	1540	1310	-1.6
World	1410	1650	1660	0.1

Source: based on data from WHO, 1996s.





**New Players for a New Era: Leading Health Promotion into 21st Century  
Fourth International Conference on Health Promotion  
Jakarta, Indonesia, 21-25 July 1997**

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## **ILLITERACY: EDUCATIONAL RESPONSES**

**Dr Elie Jouen**



**4th INTERNATIONAL CONFERENCE ON HEALTH PROMOTION**  
 21-25 July 1997, Jakarta, Indonesia

Panel Presentation in session 5 "Health 2020"  
 by

**Elie JOUEN**  
 Deputy Secretary General of Education International  
 on the theme: *"Illiteracy: Educational responses"*

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Madame Chairperson

Distinguished Participants,

The problem of illiteracy appears at two separate levels: firstly, with regard to those who are old enough to work, in other words, those between the ages of 15 and 65; and secondly, with regard to children younger than 15, who start their education.

**The global situation of illiteracy in the world today remains preoccupying and I would like to give you some figures which confirm this judgment.**

For those young people and adults aged between 15 and 65, it is estimated that, on a global level and on the basis of UNESCO statistics, almost one billion human beings out of a total<sup>13</sup> world population for this age group of four billion, are illiterate. We can therefore clearly state that 25% of today's global working population is illiterate: this global percentage naturally conceals strong disparities between men and women and between continents.

For those children who are younger than 15, two major problems are apparent: firstly, the net rate of primary school enrollment which, according to UNICEF, reaches 85% in developing countries and stands at only 50% in less developed countries; and, secondly, the percentage of children who enter the first year of primary school and reach the fifth year of primary school, which reaches a level of 75% in developing countries and 57% in less developed countries.

Above and beyond these percentages, one particular reality is clear: the problem of illiteracy remains unfortunately a major issue, which has multiple consequences on the economic and social development of many countries, and which confines a quarter of the world's population and entire regions of the world, and in particular in the African continent, in conditions of absolute poverty.

The world illiterate situation has to be taken into account by this conference because it constitutes a real obstacle to the Health promotion strategies, we all want to achieve.

The international community has naturally taken note of this dramatic situation, and is attempting to modify it. The most spectacular initiative has been undertaken by four international organisations: the UNDP, UNESCO, UNICEF and the World Bank, through the organisation of the Jomtien Conference in March 1990, which led to the adoption of the "World



*Declaration on Education for All*". In addition, a number of non-governmental organisations have multiplied their efforts in establishing extremely decentralised literacy programmes in villages, in neighbourhoods and in the workplace, many of them specifically targeted towards women.

## **Schools influence health**

We know that schools have a powerful influence on health and that, by simply attending school, children's health is improved.

Mothers who have even one year of schooling take better care of their children. They are more likely to seek medical care for their children and to have their children vaccinated. In developing countries, as literacy rates go up, fertility rates tend to go down. Literate women tend to marry later and are more likely to use family planning methods to space out the births of their children, protecting their own health and that of their children.

Schools also help children, adolescents acquiring valuable knowledge, attitudes, values, skills and services that they need in order to stay healthy and to avoid important health problems. The promotion of healthy lifestyles and conditions that can contribute to both immediate and long-term gains in health for individuals, families, communities and nations, also protects and maximises the gains achieved by teachers through education.

For example, based on discussions with colleagues from the WHO Health Education and Health Promotion Unit, we are convinced that several health problems in developing countries, can be prevented or controlled through efficient and cost-effective school-based  
114 treatments and education. This is equally valid for any measures aimed at preventing the spread of the AIDS virus.

Finally, let me add that there is an increasing lack of safe places within our societies today. Many children are subjected to social, cultural and physical conditions which do not provide them with any sense of safety or security. Schools which provide safety and security, and which serve as a setting in which individuals can demonstrate care, concern, respect, responsibility, friendship and values for one another, both preserve and enhance our efforts to educate children to a better future.

## **We have just seen that schools influence health, but health also influences education.**

As educators, we can clearly see that healthy children are more capable of learning and take full advantage of every opportunity to learn, and that all efforts in education have the potential of achieving the greatest results.

We also know that school attendance is affected by health and health-related factors, such as illness among children and their families, lack of water and sanitary facilities at school, and fear of violence and abuse both in and around school. Children who are ill, hungry, malnourished, or tired are not capable of taking full advantage of the opportunities to learn.

In addition, early or unplanned pregnancy, violence, sexually transmitted diseases and other preventable health problems, disrupt the learning process, and jeopardise the potential of many students in whom much time and effort has been invested.



It is therefore obvious that education and health are interdependently linked and that each feeds on the successes and failures of the other.

### **Priority lines of action in the fight against illiteracy**

As mentioned in the interim report submitted last year to the Mid-Decade Meeting on the International Consultative Forum on Education for All, held in Amman (Jordan): *"Rhetoric has not always been matched with action and, despite its' currency, 'Education for All' is often reduced to 'schooling for all'.* The Forum has expressed concern over several issues including the following:

- more resources must be found for education;
- the recruitment, training and status of teachers must be improved;
- the quality of education must be improved in order to enhance scholastic achievement;
- greater emphasis is still required on girls' and women's education;
- greater attention needs to be given to the development of adult literacy and numeracy skills and the sustenance of these skills.

### **Which priority lines of action in favour of health education have to be proposed and implemented to give more visible place to the concept of Schools Health Promotion?**

The WHO and Education International have already worked together on certain objectives, such as:

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- defining and promoting the concept of a nation's schools becoming *"health promoting schools"* in order for them to play a significant role in determining whether the next generation is educated and health;
- bringing together health and education officials, teachers, union leaders, students, parents and community leaders;
- striving to provide a healthy environment, school health education, and school health services

### **Seeking answers to difficult problems**

The complementarity and, to use a more modern expression, the interactivity which exists between education and health are recognised and acknowledged. In order for this complementarity and interactivity to be applied, political will and commitment are required, but the release of financial resources is equally essential. What obstacles effectively deter or delay a greater level of interactivity between education and health? To assist reflection on this issue and to provide substance to our discussion during this session, we should ask ourselves a few essential questions:

1. In our societies, affected by a certain withdrawal of state authorities and its' capacity for providing finance, affected also in some of them by the consequences of the structural adjustment policies, do we feel that the implementation of priority actions

aimed at fighting illiteracy and promoting health education will be facilitated or hindered?

2. Even if they are convinced of the necessity for implementing priority actions aimed at fighting illiteracy and promoting health education amongst their populations, many developing countries do not have at their disposal the necessary financial resources to undertake such initiatives. How could international solidarity be effectively applied in this case?
3. Poverty and exclusion are not only characteristics of developing countries. The situation in a number of industrialised countries is worsening with regard to access to medical care, according to standards used within these countries themselves. Are these situations a result of economic factors, or are they an indicator of a deeper malaise which will play an ever greater role in our societies in the run up to 2020, the horizon towards which we must direct our discussions in the framework of this panel?

I wish we all bring answers to these questions during this conference to achieve the challenge of leading Health Promotion in the 21st century.









# **HEALTH PROMOTION**

## **TOWARDS THE 21<sup>ST</sup> CENTURY**

### **INDONESIAN POLICY FOR THE FUTURE**

By :  
**Prof. Dr. Sujudi**  
Minister of Health  
Republic of Indonesia

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Keynote address presented before the  
**Fourth International Conference on Health Promotion**  
Jakarta, 23<sup>rd</sup> July 1997



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## **HEALTH PROMOTION TOWARDS THE 21ST CENTURY INDONESIAN POLICY FOR THE FUTURE**

**by Prof.Dr. Sujudi  
Minister of Health, Republic of Indonesia**

Honourable Director General of WHO,  
Honourable Regional Directors of WHO, EMRO, WPRO and SEARO,  
Dr Ilona Kickbusch, Director Division of Health Promotion,  
Education and Communication WHO HQ,  
Excellencies Ministers of Health,  
Distinguished Members of the Executive Boards,  
Distinguished Participants,  
Ladies and Gentlemen

It is an honour for me to deliver this keynote address before this august gathering. Allow me first to start with WHO definition of Health Promotion which read "Health Promotion is the process of enabling people to control over and to improve their health"

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In other words, Health Promotion is the process of empowering people to live a healthy life. Enabling or empowering people cuts across various sectors of development which is inextricably interwoven. Hence we must prudently identify which sectors have the greatest positive or negative impact on health for setting up priority of the health promotion programmes since resources for health is usually scarce.

In empowering people, three factors have been identified as having greatest influence namely education, economic and health which coincides with indicators forming the Human Development Index. Therefore, it goes without saying that empowerment in education will have its positive repercussion on the empowerment of economic and health and vice versa. In line with this, Indonesia embarks upon various innovative



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approaches. In the field of education, *compulsary nine year basic education* was initiated in 1994. In the field of economic, *poverty alleviation*, by provision of revolving fund grant through special Presidential Fund for poor villages, around 22,000 in number, was started in 1994 for three consecutive years; other measures include the establishment of *Family Welfare Savings*, *Family Welfare Credit* and some economic partnership between the big and the small businesses.

In Health, eradication of Poliomyelitis, supplementary school feeding and control of Iodine Deficiency Disorders are some interventions taken to improve health of the community.

Excellencies, honourable and distinguished participants,

A question to be asked to ourselves is, why is health promotion gaining more and more momentum? Is it because the other aspects of health care, namely preventive, curative and rehabilitative intervention, fail or losing its significance?. The answer is of course not necessarily so.

As we all aware of, the environment - the physical environment, the social and economic environment and the political environment - is the most influential factor affecting health, be it supportive or damaging to health.

Rapid changes of those environments either occurring at the local, national, regional or global level have brought about unprecedented impact to health which ultimately resulted in changes of disease pattern, in developed and developing countries alike.

On the one hand non infectious diseases such as cardiovascular diseases, cancer, diabetes, drug abuse, accidents and other disorders closely related to changes of healthy life styles, dominate the disease pattern.

On the other hand, many developing countries, are still plagued by many infectious diseases, aggravated by the new, emerging as well as the re-emerging of infectious diseases such as Ebola Virus, Malaria, Tuberculosis, Cholera and HIV/AIDS.

These intricate phenomena are not totally due to the failure in our preventive, curative and rehabilitative efforts; it is more related to our inability in adapting to those rapid





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changes. We then turn our head to Health Promotion because we believe health promotion is more cost effective, and as welfare improved, the community as well as the political leaders are more health conscious thus they are willing to participate actively in health related matters, leading to various forms of partnership.

Excellencies, honourable and distinguished participants,

Health is a social goal. Hence, a responsibility for it has to be shared among all concerned sectors.

This was reflected in the Primary Health Care approach as enunciated in the 1978 Alma Ata declaration. It encompasses various issues such as community participation, intersectoral collaboration, equity, effectiveness and efficiency which are all important to achieve the goal of Health For All. Implicit in the Primary Health Care approach is the need to build partnership among various actors related to health.

As time goes by, more and more potential partners were identified. It includes trade bodies, lifestyle and leisure industries related to food, drink, sports, entertainment, fitness, tourism or association representing consumer interest. The *National Immunization Week*, started in 1995 develops partnership with many new partners in mobilizing around 23 million underfives.

The theme of this fourth international conference *New Players for a New Era, Leading Health Promotion into the 21st Century* is thus fully in line with the recent progress of our health development because one of its objective is to facilitate the development of partnerships to meet global challenges.

Excellencies, honourable and distinguished participants,

At the very outset of Indonesian national development, launched in 1969, health has been enunciated as an integral part of the total development. Hence it is realised that health does affect or being affected by other sectors.

Our national development, until to date is guided by the *Trilogy : growth, equity and*

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*national stability* with different emphasis given to each component as development progresses. For instance, during the initial phase of the long term development plan emphasis was put on growth and national stability whereas now after achieving sustained substantial economic growth (an average of 7%) and national stability emphasis shifts to equity.

Indonesia is proud of her achievement after 52 years of independence, considering various problems and constraints encountered. First, Indonesia consists of more than 17,500 islands, the largest archipelago in the world, which stretch from the west to the east like *a string of pearls on the equator*, covering a land area of 1.9 mill. sq.km and 7.9 mill.sq.km of sea. Second, Indonesia is the fourth most populated country in the world, totaling 200 million in 1997 and a growth rate of 1.66%, with 36% urban population. Third, more than 300 cultural groups each with its own language or dialect inhabit the country. Despite these, we are fortunate to have our national philosophy- *Pancasila*- as well as our national motto : *Bhinneka Tunggal Ika* or Unity in Diversity, which have facilitated the attainment of the national stability and national resilience.

In the field of health, remarkable results were achieved. Infant Mortality Rate dropped to 55 per 1000 live births while life expectancy at birth reached 63 years. Blindness due to vitamin A deficiency was eliminated. Polio will soon be eradicated. Despite these encouraging results, many problems lingers on. Maternal Mortality Ratio is unacceptably high, 390 per 100,000 live births. Around 40 million live in Iodine Deficient susceptible areas. Cardiovascular diseases is now the number one killer and Cancer, accident and drug abuse are increasing.

This double burden has prompted the Government of Indonesia to reform or to reorient its health sector. Emphasis is given to a set of most cost effective interventions having greatest leverage on the health status, known as the basic health package, which is mostly preventive and promotive in nature. *Health education*, immunization, nutrition, STD control, MCH, Tuberculosis control and School Health are some of the components of the package.





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A pre-paid managed care known as *Community Health Maintenance Assurance Program* or JPKM has been established. To date its coverage reaches 20% of the total population. JPKM emphasizes preventive and *promotive* measures delivered in an integrated manner with curative and rehabilitative care. In the long term it could curb the spiraling health cost as well as improving the equity and the quality of health care.

Excellencies, honourable and distinguished participants,

Since this is the fourth international conference, it is worthwhile to look back to the three international conferences on Health Promotion held so far and see its consistency in selecting the theme.

The first conference in Ottawa in 1986 selected the theme *The Move towards a New Public Health*, yielded Ottawa Charter with five health promotion action programmes namely : *build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services*. Healthy public policy was discussed in the Second International Conference held in Adelaide, Australia in 1988, while supportive environment were further discussed in the Third International Conference coveyed in Sundsvall, Sweden in 1991. The five action programmes are interdependent but healthy public policy is of utmost importance since it create the environment that makes the other four possible. 123

In building healthy public policy , the Government of Indonesia has made the *analysis of environmental impact*, compulsory to all new developmental project either owned by the government or the private sector. Work is now under way to incorporate also the health impact. More and more governmental office space has been declared non smoking area. Preservation of mangrove forest which among others will reduce malaria transmission in some areas is strongly pursued.

Other examples are diversification programme for food and nutrition, of the Department of Agriculture. Safe water supply for the rural as well as the urban slum areas, by the Department of Public Works. In West Jawa province the governor collects a marginal





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amount of money from all households to be used for building safe water supply and sanitary facilities.

Of special interest is the work of the *Family Welfare Movement or PKK* in delivering preventive and promotive health care through the so called *Posyandu or Integrated Health and Family Planning Post*. Services delivered are MCH, Immunization, Case Management for Diarrhea, Health Education and Family Planning.

In building supportive environment, the Government of Indonesia has taken various steps such as enacting a new health law in 1992, law on Psychotropic Substances and law on Narcotics which is being discussed by the parliament. *Gender equality* is strongly pursued to promote better opportunity for women to participate in the national development.

*Decentralization* to the district level has facilitated better cross sectoral collaboration conducive to health promotion.

124 Excellencies, honourable and distinguished participants,

In setting the policy for Health Promotion in the 21st century, considering the nature of health promotion that is cutting across various sectors, trend analysis of the health problems and the environment which influence it is indispensable.

Trend analysis conducted in Indonesia so far revealed among others rapid urbanization and ageing of the population. By the year 2010, around 50% of the population live in urban areas and the number of the elderly - those aged over 60 - equals the number of the underfives.

Healthy cities and care of the elderly are therefore one of the main target for health promotion.

Some of the policies of Health Promotion in the 21st century for Indonesia are as follows :

a. Continue the development of Healthy Public Policy. As many sectors as possible will



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be requested to pursue this.

b. Select priority sectors or actors to work with. Since resources are always scarce, the greatest positive impact on health can not be achieved if those resources are spread out thinly to many sectors or to many actors.

c. Create alliance with old as well as with new partners at all levels.

d. Increase individual skills through education and training to increase the awareness, willingness and capability of the respective individual in self help.

e. Strengthen community action through community development to enable them to control over and to improve their health.

f. Sustain the Health Sector Reform. To enable the health sector to cope with the rapid changes occurring at all levels, continual reform is justifiable.

Excellencies, honourable and distinguished participants,

To conclude I wish to reiterate the importance of economic and education empowerment in health promotion. Evidence is accumulating worldwide that health will deteriorate whenever the economic of a country is hit by a political turmoil while countries making heavy investment in education are having high health status.

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I wish you a successful conference. Thank you.





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## **SPEECHES AND PRESENTATIONS**

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## **THE CHANGING SHAPE OF GLOBAL HEALTH PRIORITIES**

**Dr D. Satcher**



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[Title]  
For the 4th International Conference on Health Promotion  
Jakarta, Indonesia  
July 21-25, 1997

***Introduction***

On behalf of Dr. Satcher, Director of the Centers for Disease Control and Prevention, who, unfortunately cannot be here, I am very pleased to speak to you at this very important conference.

As we think about working collaboratively with new partners and together leading health promotion into the 21st Century, let us take a moment to look at the context in which this new era is occurring.

***The changing shape of global health priorities***

We are facing a time towards the end of this millennium, and near the beginning of a new millennium, where global health priorities are shifting from a focus on traditional infectious diseases to a focus on chronic diseases, newly emerging infectious diseases, nonintentional and intentional injuries, environmental health, and mental health.

We are facing this shift of disease burden in the midst of an increasing ageing population, and increasing urbanization, violence, and gender and racial inequities.

But the critical thing to note, particularly here in a health promotion context, is that regardless of disease condition or



conditions, interventions can increasingly be tied to behavior, whether it be individual, organizational or health care behavior.

Behavior is the final common pathway

### ***Building Capacity***

There is growing recognition that public health problems arise and affect people anywhere in the world, transcending national boundaries. Therefore, public health solutions can be best addressed by cooperative actions and solutions which come from and are shared among regions and countries.

Strengthening our relationships with existing partners and working with new partners will greatly help to solidify and expand our impact on world health.

- <sup>130</sup> CDC's vision of "Healthy People in a Healthy World--Through Prevention," conveys the agency's global perspective. The concept of the global village has traditionally guided CDC activities in global health.

CDC has from its inception made contributions to improving health and well-being around the world through global disease control and prevention.

CDC believes in the concept of "global assistance for local ownership" and aims to foster sustainable institutional and organizational capacity and competence for protecting people from disease and promoting healthy lifestyles throughout the

world.

CDC is committed to improving global health by:

- Strengthening and facilitating the efforts of other international health organizations, including assignment of technically knowledgeable staff to organizations such as the United States Agency for International Development (USAID), WHO, UNICEF, and the World Bank;
- Providing short- and long-term consultancies;
- Conducting capacity development programs, e.g., training relief agency personnel in emergency preparedness and response to infectious disease outbreaks, which has long been a staple of CDC's international work;
- And, applying CDC's global mission which is to promote health and quality of life by preventing and controlling disease, injury, and disability.

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CDC accomplishes its mission by working with partners in the U.S. and abroad to:

- Monitor health
- Detect and investigate health problems
- Conduct research to enhance prevention
- Develop and advocate for sound public health policies
- Implement prevention strategies
- Promote healthy behavior
- Foster safe and healthful environments



- Provide leadership and training

It is in the monitoring of health, or, more specifically, the behaviors which place people at risk for disease, that provides a foundation on which health promotion and prevention efforts can be based. Ongoing, systematic monitoring of health risk behaviors provides appropriate and useful data on which to plan or guide these programmatic efforts.

CDC has worked with a broad spectrum of partners, including individual sovereign nations, multilateral organizations, U.S. Government agencies, and nongovernmental organizations.

132 And the lessons learned have been bi-directional. The United States benefits greatly from the experiences of other countries. At the same time CDC's skills and experiences are enhanced, our global partner's own public health capacity is strengthened as well.

These lessons learned include improved understanding of public health problems, the development of new methods and strategies to combat these problems, the improvement of services or programs, consensus on international norms and standards, and shared benefits that accrue to multiple countries when they take collective action on priority health problems.

As ideas develop and are systematically applied in a number of international settings, our understandings are enhanced, thus leading to further improvements in both domestic and global activities. CDC believes that by thinking and acting globally,



we continue to become a better prevention agency in our own country.

### *Global Partnerships: One Collaborative Example*

The Mega Country Health Promotion Network, which is a component of the health promotion five-year action plan developed by the World Health Organization, is an excellent example of a collaborative effort among global partners to promote world health. The goal of the Mega Country Health Promotion Network is to mobilize the world's most populated countries to promote health in a concerted, collaborative effort.

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There are 10 countries with a population of at least 100 million and together these 10 countries make up approximately 60% of the world's population. These countries are:

- Bangladesh
- Brazil
- China
- India
- Indonesia
- Japan
- Nigeria
- Pakistan
- Russian Federation
- United States

By the year 2000, Mexico also will have a population of 100 million.

While Mega countries possess the potential to set goals and targets directed at enhancing the health of their own populations, they also possess the potential to provide leadership in promoting and protecting the health of the world's populations.

The objectives for the Mega Country Health Promotion Network include:

- Improving each country's own national capacity to promote health.
- Identifying priority areas on which the network can focus, which can be centered around health issues (e.g., chronic and infectious diseases, mental health, and environmental health), population groups (e.g., youth/children, women/mothers, and the ageing population), and settings (e.g., communities, schools, and worksite).
- Selecting action areas and activities to work on together.
- Providing support to other nations in the region or world.
- And, building partnerships with federal and non-federal agencies, universities, and private industry. It is through these partnerships, working with new players in a new era, that true progress can be made in improving world health.

Criteria for participation in the Mega Country Health Promotion Network include demonstrating a government commitment to health promotion, providing adequate communication technology (E-mail and fax connections), and identifying country focal points to facilitate communication and ensure continuity.

A feasibility meeting was held in 1996 and representatives from these Mega countries concluded that this network is a “value-added” activity. [Note: representatives from China, India, Indonesia, Japan, the Russian Federation, and the United States attended.]

In April of this year, a formal Mega Country Health Promotion Network meeting was held in Atlanta, Georgia USA. At this meeting we began to identify the purposes, products, processes, partnerships, and priorities of this collaborative health promotion initiative; develop infrastructure; and establish communication mechanisms between countries. [Note: representatives from Bangladesh, China, India, Indonesia, Pakistan, the Russian Federation, and the United States were in attendance.]

At this 4th Annual Conference on Health Promotion, you will find copies of a provisional vision statement for the Mega Country Health Promotion Network, as well as a summary of the recent formal meeting. [Hold up.] Please pick up a copy.

## Summary



As we begin the Mega Country Health Promotion Network at the end of this millennium, strengthening old partnerships and collaboratively working with new partners from a number of nations and from various agencies across the private and public sector, we contribute to world health in a significant way. We see the need for strong research and practice addressing behavioral change to improve the public health of nations.

CDC believes that the concept of globalism, grounded in the tradition of humanitarian concern and social justice, and applied to public health practice and research, is an important part of our overall mission. It is through our global partnerships and the linking with partners that, together, we can truly help lead health promotion into the 21st Century.







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### **HEALTH CHALLENGES IN THE NEW CENTURY. HOW TO MEET THEM IN THE MOST POPULOUS COUNTRY**

**Dr Lu Rushan**



# Health Challenges in the New Century -- How to Meet Them in the Most Populous Country

LU Rushan, China

## 1. Present Situation

Since the founding of the People's Republic, China has made achievements in health service. By 1995, half of the counties in this country had met the basic health requirements set by the government for the rural areas. Legal systems concerning health services have been strengthened. The Patriotic Health Campaign has been going on well, and some of the most dangerous diseases have been under control or eradicated. With the life expectancy going from 35 of age in 1949 to 70 of age today and with the infant mortality going down from 200 per 1,000 to 31.4 per 1000, the health status of the people has been improved.

Nevertheless, to meet the needs of further health and socialist market economic developments, much more needs to be done.

## 2. Health Challenges in the 21<sup>st</sup> Century

Health care challenges in the 21st century are indeed huge and grave in China. In this paper we just mention a few of these challenges.

**2.1. Disease prevention and treatment.** On the one hand, some infectious diseases and endemic diseases, although the prevalences are low, are not yet totally under control, and infectious diseases newly emerged elsewhere in the world may invade China. The chronic non-infectious diseases such as cardiovascular and cerebral vascular diseases, tumors, etc. have become the five most common causes of death, most of these diseases are closely linked with tobacco epidemic. Health services now in China have the "double burden". 139

**2.2 Large population in the rural areas.** Health care in the rural areas is still quite inadequate in terms of its basic services. In the most remote areas live almost 60 million peasants under the poverty line, and some of them cannot afford medical treatments. Some have become poorer because of illnesses, and some who were better of some time ago are now having a hard time due to illnesses. Diseases are now an obstacle for the peasants who are encouraged to get rich through their own efforts. The overall health situation in China depends largely on how the health care in the rural areas is improved, where most of the population reside.

**2.3. Industrialization and urbanization.** Because of industrialization and urbanization, there came diseases caused by environmental pollution, occupational reasons and behaviour changes, such as drinking, smoking, and drug abuse, as well as STDs, AIDS, and accidents. All this is on



the increase, especially when the surplus rural peasants leave their home places and come to find jobs in the cities, and the cities have the new groups of "temporary workers". Those people, together with their family members, go from city to city in all provinces, forming quite a large flowing population. Their health care is not only important in itself but also important for social stability.

**2.4 Population growth and aging.** In 1996, China's population has reached 1.22 billion. The population is increasing at an annual rate of 6.6 per 1,000. The growth rate of population is still alarming. In addition, as the life expectancy has become longer, there are more senior citizens (> 60 years old). In 1964, 6.08% of the China's population was senior citizens, while in 1994, the figure was 9.76%. In fact, some cities have already become aging communities, and in the near future, the whole of China will have a national problem of aging population. Special attention must be paid to the elderly health.

### **3. General Goal and Guidelines of Health Care in China**

To meet these challenges, the Chinese government, in keeping with the health conditions in this country, has set the general goal for the near future. That is, by the year 2000, a basic health system that includes health services, medical care, health legislation and supervision will be established, the goal of Health for All will be basically realized, and people's health will have been further improved. It is expected that, by the year 2010, a complete health system will have been established, appropriate to the socialist market economy system and to the health demand of the community.

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In China, health care services cannot be dealt with in a way developed countries have done in the past - with too high cost. Nor should they be treated the way China did in the past - not appropriate to the current socio-economic development. A health system with Chinese specific features must be taken to serve the people for their health needs and for the socialist modernization. In this system, health education, health protection and health promotion are very essential. The working principles of health service in China at the new stage are "focusing on the rural areas, putting prevention first, placing equal emphasis on both traditional Chinese medicine and the Western medicine, relying on scientific/technological progress, and mobilization community participation".

### **4. How to Meet these Challenges**

#### **4.1 To Strengthen Health Services in the Rural Areas and to Reform the Urban Health Service System**

Health service system is the important infrastructure of the health promotion efforts, the stronger the infrastructure is, the better health promotion will be. Health services in the rural areas play

a critical role in protecting the health of China's near 900 million peasants, and thus should be the very focus of China's health care system.

Cooperative Medicare systems should be developed and improved, which will provide the peasants with the basic medical services, primary health care, prevention of diseases that cause peasants to become poorer. By the year 2000, most of the rural areas will have various kinds of Cooperative Medicare systems set up, and will move toward a more socialized system. In some areas, the systems may go and change, if possible, into medical insurance systems.

A 3-tier health care network that covers the county, the township and the village should be further improved. County hospitals should be of good quality, and be able to provide all types of medical services. Township hospitals must stress the prevention work, improve service qualities, and especially focus efforts on first aids and baby delivery work. Village health stations are run collectively.

Attention should be given to the poorest areas as well as the places where the minority people live. Plans for health services should be included in all the government programs of "aids to the poorest".

In urban areas the health service at community level is to be actively developed, so as to establish a network of health service convenient to local community step by step and to advocate the health promotion efforts there. Health institutions at the grassroots level should provide the service to the local community and family in disease control, in diagnosis and treatment of commonly-seen and frequently-occurred diseases, in therapeutic and rehabilitative services of the disabled, in health education, in technical service relating to family planning, in MCH service, etc. A good referral system should be established by the year 2000.

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#### **4.2 To Ensure Disease Prevention and to Strengthen Health Promotion**

Policy makers and local governments should take full responsibility for public health, for improvement of conditions of the health institutions, and for provision of the necessary funds for the prevention and control most of the diseases. Prevention and treatment of diseases that are closely related to one's life styles should be given enough attention, such as cardiovascular and cerebral vascular diseases, tumors, diabetes, etc. Capabilities should be raised to swiftly respond when emergency injuries occur and when contagious diseases break out.

Health promotion efforts should be very much reinforced. The patriotic health campaign in China is one of the excellent forms of health promotion and community participation in health services and it should be continued to carry on. In tackling the determinants of health, health promotion will include individual health behaviors, and social, economic and environmental conditions. Comprehensive strategies of health promotion are the most effective in addressing the multiple determinants of health. Health knowledge is an important part of the education that the general public should get, and therefore health education should be given quite a lot of attention. The



population should be well informed to protect themselves, so that they can get rid of their superstitions and bad habits and instead learn to take part in fit-keeping activities, balance their nutrition, form good habits, lead a civilized life and enjoy a healthy mentality. In the development of health promotion programme, a special attention should be given to the school children, so as to implement the health promotion activities through school and to keep them healthy all the time. A couple of years ago, in collaboration with WHO and with the strong support from WPRO/WHO we have already tried out some modules for health promotion. More than 30 health promoting schools have been established. Health promotion in work places have been tested in 4 big enterprises in Shanghai, and 4 health cities have also been achieved. There were very promising results from these pilot projects. It is clear that the approach of health promotion is the most active and cost-effective way to deal with health issues. Based on this experience more "health cities" should be established in the future. In rural areas, the focus is still on the improvement of water supply and latrines to change the overall health conditions there and prevent or reduce diseases. "Civilized villages and towns" should be encouraged, and the "Health Education for the 900 Million Peasants Action Program", as an important part of the health promotion activities in the rural areas, should be further strengthened. Both the cities and the rural areas should keep on the patriotic health campaign to get rid of the four pests: mosquitoes, flies, rats and cockroaches.

Environmental health monitoring and prevention of occupational diseases are also vital in the protection of people's health. Pollution of the environment at the cost of people's health for short term economic gains should never be allowed.

#### **4.3 To Strengthen Health Protection for the Vulnerable Groups**

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For the vulnerable groups of people, their health protection should be registered. Maternal and child health care must be emphasized to raise the quality of health in the population, and reduce infant mortality and the death rates of pregnant women. Stress should also be given to health care for senior citizens, so that they will have a health expectancy and given to health care and rehabilitation facilities for the disabled.

#### **4.4 To Join Forces with Other Social Sectors and Organizations, and to Encourage International Cooperation**

Development of health care system relies largely on the overall social and economic situation of the country. It is obvious that with participation of other sectors, NGOs, academic institutions, etc. and with the establishment of partnership with them, the cooperation among all the players, guided by the governments at all levels, in providing health care is extremely important. For example, programme of total balanced environment, safe drink water supply, high level of literacy, etc. without the multisectorial commitment and the cooperation will be able to be done.

As I mentioned above, the "Health Education for the 900 Million Peasants programme" is a good example to show the importance of participation of all the players. The action programme was



initiated by Ministry of Health, Ministry of Agriculture, Ministry of Broadcasting, Television and Cinema, and the National Committee of Patriotic Health Campaign in 1994. It is a joint undertaking of 4 ministries. Now the programme is implemented throughout the country in a very successful manner and will be further strengthened. The same is true with bilateral and multilateral (international) cooperation. Foreign experience and expertise should be studied and adopted, and channels for cooperation should all be opened up.

China is a developing country, with the largest population, but not much to start with in health care at the beginning, and is now running the biggest health care system in the world. It goes without saying that there are difficulties, and that governments input is far from enough to meet the ever-increasing needs of the people. Governments at all levels, though their budgets are all very tight, are requested to give as much financial support as possible to health care by various means, and to increase health care input as they have more financial revenues and make sure that the growth rate of health care input should not be less than that of the overall financial expenditure. Health care is largely of a social nature, and governments can only be involved to certain extent and society and individuals must do their bit and pay part of their own medical expenses and health services.

It is indeed a glorious cause in this period of time when we are entering a new century to develop health care services for the benefit of the general public. We believe that only when the health promotion and health protection are well under way, can the sustainable health and sustainable socioeconomic development be guaranteed in China.

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Now he is also asked to be Secretary General of the "10th World Conference on Tobacco or Health" to be held in Beijing from August 24 - 28, 1997.







**New Players for a New Era: Leading Health Promotion into 21st Century  
Fourth International Conference on Health Promotion  
Jakarta, Indonesia, 21-25 July 1997**

## **SPEECHES AND PRESENTATIONS**

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### **EUROPEAN APPROACH IN HEALTH PROMOTION**

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European Commission  
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## European approach in health promotion

European Union with its 370 million citizens in 15 Member States form a challenging forum for health promotion. This challenge is in fact even bigger because the European Economic Area countries (Norway, Iceland and Liechtenstein) and gradually also the countries in Eastern and Central Europe, which are applying membership in the Union, are partners in the public health development of Europe.

It was not until 1993, when the Maastricht Treaty on the European Union came into force, that the European Community gained a specific competence in public health allowing the creation of a coherent Public Health Strategy. Article 129 of the European Treaty actually states that emphasis should be given to Health Promotion and the Prevention of Diseases. This statement was re-enforced and strengthened in the Amsterdam Treaty, which currently is in the ratification process in the Member States.

### **1. Community Action Programme on Health Promotion, Information, Education and Training**

The European Parliament and the Council officially adopted the Health Promotion Programme in 1996, with a total budget of 35 MECU, for a period of 5 years. The Commission supports transnational projects, which demonstrate that they will contribute to enhancing a healthier Europe. Participation in the programme from actors in all Member States, the EEA countries (Norway, Iceland and Liechtenstein), and now also from certain Applicant Countries is welcomed.

#### *The Framework*

The cornerstones in health promotion are to ensure the availability and affordability of healthier choices of goods, environments and services. It is important to create a supportive way of thinking and physical, social, economic, cultural and spiritual environments that recognise the rapidly changing nature of our society. Local community actions have to be strengthened. Personal skills have to be developed to enable people to have the knowledge to meet the challenges of life and to take care of their health.

The aim is to promote health not only within the Member States but also throughout Europe as a whole. Co-operation is strongly encouraged with the EEA countries as well as with countries of Eastern and Central Europe.

The Community Action Programme encourages Member States to put Health Promotion high on the agenda and to pool their ideas and experiences. It encourages the adoption of healthy lifestyles and behaviour, and raises public awareness of risk factors and health-enhancing aspects, by suggesting healthy alternatives and means for disease prevention. It also promotes intersectoral and multidisciplinary approaches to health promotion, emphasis being on determinants of health, taking account of the socio-economic factors and the physical environment.

A Programme Committee, consisting of two representatives from all Member States and the EEA countries, meets twice a year to discuss the priorities of the work programme and to give their opinion on projects selected for funding.

The health benefits of the programme are relayed across Europe through the media of European networks dealing with prevention and health promotion issues. The networks may consist of governmental and non-governmental organisations, academic bodies and institutions of higher education. Particular attention is given to developing health promotion capacities and establishment of partnership agreements, with priority on putting existing knowledge into practice.

The key to disseminating health promotion throughout Europe is exchanging know-how and **demonstrating models of good practice**. A European network of Health Promotion Agencies, one of the main networks of the Health Promotion Programme, does precisely this.

The priorities of the programme are placed on four dimensions, which are intersecting each other: Issues, settings, population groups and quality development.

#### *Priority issues*

Measures at European level are being discussed and supported as for example the prevention of drinking and driving and the consumption of **alcohol** by minors. Support is offered to collect and provide comparable data and structured information in relation to these issues. A working group of experts from all Member States with scientific, political and social economical backgrounds has been set up to advise the Commission in this field.

Practices on supporting **healthy diet** will be developed. A workshop will be held involving scientific experts from Member States. This will result in advice to the Commission on nutrition and healthy diet policies.

Based on a strategy paper drafted by a group of experts from the Member States, a plan is being drawn up concerning a European **Heart Health Initiative**. A broad discussion and mutual priorities on this issue will be actively supported.

A European network has been set up with the aim to facilitate and encourage the promotion of public health via **Health-enhancing physical activity (HEPA)** in Europe. This is being accomplished through co-operation and exchange of knowledge based on research and experience. The long-term goal of the European network is a substantial growth in the number of citizens of EU Member States who enhance their health through regular exercise.

Priorities will be identified based on the findings of a project to set up key concepts for actions in **mental health promotion**. As a result, these ideas will be further developed and given concrete expression by the European Network of Mental Health Promotion.



A group of experts representing all Member States is currently finalising on a report on the preventive measures of **osteoporosis**. Based on this, recommendations have been drawn up for health professionals, decision-makers and the general public.

### *Settings*

The European Commission has a joint project on **Health Promoting Schools** with the Council of Europe and the European Regional Office of the World Health Organisation. Over 500 schools are covered in 37 different countries, with view to providing opportunities for young people to gain knowledge and insight and acquire essential life skills.

The European network for **Workplace Health Promotion** determines and distributes examples of good practice of working conditions in the Member States, with special emphasis on small and medium-sized enterprises. The relevant issues covered in this context are the misuse of alcohol, nutrition, mental and physical health, medication and its use.

A network of health administrations in **Capital Cities** is in the process of developing a shared agenda for health promotion in big city setting. Priority is given to the elderly population, youth and young families, and disadvantaged groups.

**Health care** professionals play a major role in health promotion and disease prevention. Key health care personnel groups will develop means to improve the role of health promotion in the daily professional practice of health care.

### *Population strategies*

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Policies dealing with young people are being debated amongst those actively working with **young** people, in sports, culture and other sectors (specifically concerning school-leavers).

Several plans of action are being set up to help health promotion for the **elderly**, and collaboration with other Commission services reinforced.

A special priority is being given to **disadvantaged groups**, primarily by a network of health promotion agencies and capital cities.

### *Training in public health*

**European Master's Degrees in Public Health** are introduced with view to increasing the European dimension and improve the quality of existing training programmes. First projects include a Masters in Public Health, in Health Promotion and in Public Health Nutrition. As many universities and educational institutions as possible will be included in this project. A directory of existing training programmes in public health and health promotion will be finalised and available via Internet. It will be regularly updated.

A **Summer School**, which focuses on the Community's Health Programmes, will be held in Luxembourg once a year. The main objective is to unite both representatives



from public health programmes and decision-makers from the Member States to explore key health issues in Europe.

### *Technical Development and Quality Improvement*

Use of **modern communications technology** is being supported in order to intensify the exchange of information within the European health promotion community and with the public. A **scientific review** and analysis of the evidence on health promotion intervention activities is being carried out.

Co-operation between the media community and health promotion communities is being strengthened. A project bringing together European broadcasters and health promotion experts is in progress on the **role of media in health promotion**. This aims to enhance our abilities to communicate vital health messages to the public and to evaluate the effectiveness and efficiency of mass media in health promotion.

## **2. Future challenges**

Health promotion is conceptually difficult and constantly evolving. At the same time there is a vital need to share the responsibilities with other sectors of our societies. Conceptual sophistication is therefore the quality of main concern but clarity and straight forwardness. We have to learn to use language that is understood of course not forgetting the importance of intellectual challenge to the development. This development is, however, of little use if it leaves the players cool and outside. In the European health promotion development the main priority has been placed on putting existing knowledge efficiently in practice.

Science has made remarkable strides in the understanding and prevention of many health issues. In many countries e.g. the cardiovascular disease death rate is considerable lower of what it was in 50's and 60's, and a range of risk factors for the disease, from smoking to nutrition and physical exercise, have been pinpointed. Cancer's biological profile is getting ever clearer because of stunning discoveries at the genetic level.

How key interventions could further reduce the burden diseases impose on human health and well being. Are we approaching the limit?

Inactivity and obesity are strongly associated with functional capacity, higher rates of heart disease and many other chronic diseases, including some cancers. Large proportions of Europeans meet the definition of being inactive, and fit the definition of obese. The health consequences of obesity alone are enormous: it can be estimated that hundreds of thousands of deaths in Europe each year can be attributed to obesity, not to speak of morbidity and decreased functional capacity.

Exercise improves the lipid profile, lowers blood pressure, and decreases the tendency for the blood to clot. Even moderate weight loss can have a positive impact on some of these health indicators.

The bottom line is that we can go a long way in promoting regular physical activity, and maintaining a healthy body weight throughout life. These changes should result in the reduction of the burden of chronic disease.

Foods and nutrition play a key role in health promotion because they have been strongly associated with an increased risk of many health issues. On the other hand nutrition can also be seen as a major potential in attempts to enhance the health of the people.

There is a mixed health profile of drinking alcohol: for men and women, alcohol in moderation is suggested to be a good thing because it is associated with lower overall mortality rates and lower heart disease rates. But it has also been found to raise the risk of breast cancer and some other health and social problems.

Because many chronic diseases have so many causes, they are challenging to health promotion. But that is good news from a public health perspective because it provides multiple avenues for health promotion intervention. By applying even the current knowledge, we can improve health and well being substantially.

To be successful in health promotion we need to understand social and environmental determinants of health, and then we can figure out what policy and infrastructure changes should be made to make improvements in people's lives.

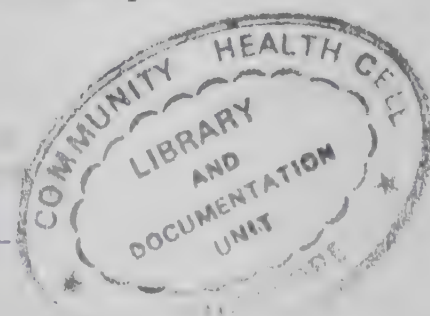
Social determinants of health include things like employment, poverty and ethnicity, gender, and many more. There are aspects of the social environment that influence health directly, as well as those that influence health via behavioural pathways. A complete list would be a long list.

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The determinants are thought as generally falling within four areas: One is social stratification, and this includes conditions related to socio-economic status e.g. poverty and employment. The second area involves social networks, by which we mean the importance of community, social integration, and the maintenance of close personal relationships. The third subject area includes the ways that e.g. ethnicity affect health, not ethnicity as a biological factor, but in how it relates to social conditions of individuals in our society. The last grouping of factors are those that are characteristics of work and work/family relationships.

In addition to the social determinants, we should be interested in behaviours and the ways that they're embedded in social contexts. Behaviours like alcohol consumption, smoking, eating, and physical activity are embedded in a larger social structure that makes changing those behaviours difficult, sometimes impossible, without addressing the social context in which those behaviours occur and making the necessary changes in infrastructures and policies.


Environmental health determinants include environmental exposures like pollution, traffic and transportation, urban structures and food. These must be equally seen as major challenges for future actions to promote the health of Europeans.





The health promotion community has developed strong experience and know-how. It has also demonstrated convincingly that health promotion is from the health and well being points of view efficient and successful, and there is still much to gain in this area. Integrated programmes in schools, workplaces, local communities and other so-called settings have proven to be both successful and sustainable. The role of media in health promotion is important, but it should always be connected with other activities and actors in this field in order to be efficient. Finally, there must be big enough investments in promoting people's health and strong, sustainable infrastructures to support and facilitate the development.





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